Adirondack Rural Health

N E T W O R K

Building a Healthy Community

Health Assessment & Community Service Plan

S E P T E M B E R   2 0 0 9

S I X   C O U N T Y   R E G I O N   O F   N E W   Y O R K   S T A T E

Essex, Fulton, Hamilton, Saratoga, Warren, & Washington

Copies of this report are available online at www.arhn.org

Table of Contents

Message to the Community

We are proud to present you with this report of the six-county Adirondack Region of Upstate New York—a comprehensive collection and analysis of data regarding health issues and needs in Essex, Fulton, Hamilton, Saratoga, Warren and Washington counties.

This study was conducted to identify health issues of primary concern and to provide critical information to those in a position to make an impact on the health of our region—governments, social service agencies, businesses, healthcare providers and consumers—to name just a few.

The results enable us to more strategically establish priorities, develop interventions and commit resources to improve the health of our communities and the region.
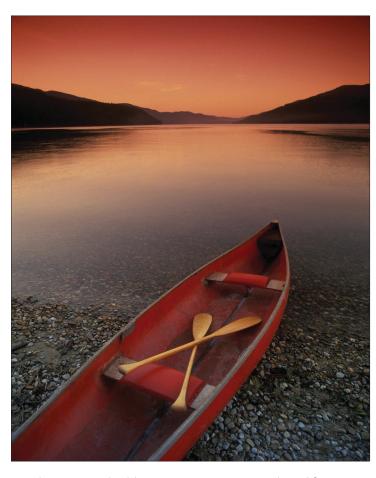
Health is—and must be—an issue of concern and action for all of us. We hope the information in this study will encourage collaboration involving all agencies, across county lines, between usual competitors, and among funders to address the complex health needs of our residents.

Executive Summary

Introduction

Established in 1992 through a New York State Department of Health Rural Health Network Development Grant, the Adirondack Rural Health Network (ARHN) is a community partnership of public, private and non-profit organizations in Upstate New York. ARHN links local public health departments, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations by creating a collaborative process for developing strategies and for implementing, monitoring and evaluating the regional health care system. The Upper Hudson Primary Care Consortium, a 501-c-3 corporation licensed as an Article 28 Central Service Facility, serves as host organization for ARHN and provides financial management, human resources, and information technology support.

Since 2002, the ARHN has been recognized as the leading sponsor of formal health planning for Essex, Fulton, Hamilton, Saratoga, Warren and Washington counties. Together with community stakeholders, the ARHN has developed and implemented a sophisticated process of community health assessment and planning for the defined region. The first ARHN regional community health assessment report was released five years ago, in September 2004. Subsequent to the report's release, the Adirondack Rural Health Network Community Health Planning Committee (the Committee) has continued to meet on a regular basis. Together, they exchange information, plan new initiatives, and develop strategies to produce an ever-current picture of the health care landscape that can be used by stakeholders throughout the region.

The planning for the Adirondack Rural Health Network (ARHN) Community Health Assessment and Community Service Plan 2009 began in August 2008 and was completed in August 2009. The process was guided by the Committee, a collaborative team including county public health professionals, hospital and community agency leadership. The Committee was supported by the work of the ARHN staff and Strategy Solutions and Holmes & Associates as research consultants.

This study was designed around the Prevention Agenda Toward the Healthiest State rationale that was released in 2008, by New York State Health Commissioner, Richard F. Daines, M.D., In this document Dr. Daines states "The Prevention Agenda is a call to action to local health departments, health care providers, health plans, schools, employers and businesses to collaborate at the community level to improve the health status of New Yorkers through increased emphasis on prevention."

The Prevention Agenda identifies ten priorities for improving the health of all New Yorkers and asks communities to work together to address them:

- Access to Quality Health Care
- Chronic Disease
- Community Preparedness
- Healthy Environment
- Healthy Mothers, Healthy Babies, Healthy Children

- Infectious Disease
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

The ARHN Community Health Assessment and Community Service Plan 2009 is intended to be a tool toward reaching the Prevention Agenda goals

Methodology

In response to this statewide call to action, the partners in the ARHN region came together in 2008 to evaluate their past efforts and continue to improve their community health assessment and intervention planning process. In 2009, the Committee was re-energized with the increased involvement of representatives from each of the hospitals in the ARHN area. Their active participation allowed the Committee to expand its research and analysis to include hospital utilization data. The hospitals' involvement also resulted in an enhanced priority setting process that addressed both the needs of the county public health departments and their required Community Health Assessment (CHA) documents, as well as the needs of the hospitals and their required Community Service Plans.

The data collection, analysis and reporting process was managed by the ARHN staff and supported through the efforts of Strategy Solutions and Holmes & Associates. From August 2008 through August 2009 members of the Committee convened fourteen times to provide guidance on the components of the six-county study.

The data collection and analysis included six key components:

- The New York State Department of Health conducted an extensive Behavioral Risk Factor Surveillance Survey (BRFSS) in 2008. The BRFSS was conducted by telephone surveys and collected information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The data is used throughout the study.
- The 2004/07 ARHN Household Telephone Survey Data
- County, region and state disease incidence, and Healthy People 2010 goals
- New York State Prevention Quality Indicator data (PQI)
- Hospital utilization data from the Statewide Planning and Research Cooperative System (SPARCS)
- Input regarding barriers to health and ideas/priorities to improve the health of the community gathered from 286 individuals and agency representatives through 24 qualitative focus groups

Demographic & Socio-Economic Data

Population

In 2009, there are an estimated 445,985 people living in the six counties of the ARHN area, with almost one-half of that population (49%) living in Saratoga County. In the 1960s and 1970s, the area's population growth exceeded that of the average for the U.S., in large part due to the population growth in Saratoga and Warren counties. In the 1990s,

population growth within the ARHN area fell below the average for the U.S. for the first time in 40 years. From 2000 to 2009 the population growth in the ARHN area was 5.1% as compared to 9.1% for the U.S. as a whole. The area's population growth is projected to continue to lag behind that of the U.S.

Age and Gender

The median average age in the ARHN six-county area is 41 years of age, which is 4 years older than the overall U.S. median age of 37. Over 27% of the area's population is within the two age categories of 25-34 and 35-44, while over three-quarters of the population (79%) are 18 or older. About 11% are under age 10 and about 15% are age 65 or older. The population pyramid illustrates that the ARHN area has an aging population.

Population Pyramid: Percent of Population in each Age Group by Gender, for the 6-County ARHN Area (2009)

Household and Household Income

In 2009, there were an estimated 179,596 households in the ARHN six-county area. From 2000 to 2009 the total number of households grew by 8.4%. The average household income is $60,425. For the U.S. as a whole, the average household income was $69,376. The per capita personal income in the ARHN area was $31,863 on average, which was less than the averages for both New York ($46,364) and the U.S. ($38,615). On average, there were 2.48 persons per household in the ARHN area in 2009, which is slightly less than the national average of 2.67 persons per household.

Ethnicity and Race

The ARHN area's current estimated Hispanic or Latino population is 2.1%, while the United States current estimated Hispanic or Latino population is 15.5%. For the ARHN area 94.8% are White, 1.9% are Black or African American, 0.2% are American Indian or Alaska Native, 1.2% are Asian, 0.0% are Native Hawaiian and Other Pacific Islander, 0.6% are Some Other Race, and 1.2% are Two or More Races. By comparison, for the entire United States 72.5% are White, 12.5% are Black or African American, 0.9% are American Indian or Alaska Native, 4.4% are Asian, 0.2% are Native Hawaiian and Other Pacific Islander, 6.7% are Some Other Race, and 2.9% are Two or More Races.

Poverty

In 2005, the ARHN region had 10.5% of the population living at or below poverty level. While lower than the overall state rate of 13.9%, it was higher than the Upstate average of 10.1%. Only Saratoga and Warren counties had rates better than the regional average. With the exception of Saratoga, all other counties had higher rates of children less than 18 at or below the poverty level than the Upstate average of 13.5%.

Unemployment

In 2008, the ARHN six-county average unemployment rate was 6% as compared to 5.4% for the state and 5.8% for the United States. There was an annual increase of 1 to 2% from 2007 to 2008 for each of the counties, as there was nationally. New York State had a slightly lower increase in unemployment of .9% for the same period. The increase in unemployment in the ARHN region from January 2008 to January 2009 indicates how much more severe the increase

in unemployment will be for 2009 as a whole. In general, the June 2009 unemployment rate of 7.7% in the ARHN counties was lower than those at the State (8.6%) or national (9.7%) levels. One exception was Fulton County where the unemployment rate was 1% higher than the State rate. The somewhat lower June unemployment rates in the ARHN area reflect, in part, the importance of the area's seasonal construction, hospitality, and service industries.

Key Findings
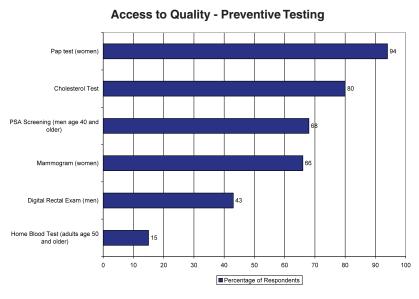
Based on this study, the ARHN area is comparable in many ways to Upstate NY, as well as the state overall, in terms of health status, behavioral risk factors and hospital utilization. Demographically, the region consists of a mix of suburbs and rural small towns, where the population is relatively homogeneous, aging and growing at a slower rate than other areas of the country. However, economic disparities do exist within the various counties and some sections of the region face significant distance and transportation barriers to accessing community resources and services. While the behavioral risk factor surveys indicate that people are becoming more aware of the importance of preventative health and screenings, there are significant health risk behaviors and chronic diseases present.

Access to Quality Health Care

Overall, the health status of the region is generally good and the majority of adults indicate that they have health insurance and access to primary health care services. The regional rates are lower than the Healthy People 2010 goals. The majority of the region accesses primary care services on an annual basis and when appropriate. Those without a dentist or physician most often cite lack of insurance or felt they were healthy and did not need one. A small but significant percentage (11%) of the population responded they delayed primary care services due to cost and lack of insurance. It is important to note that in some of the ARHN areas the regional distribution data indicates as much as a 5% decline in the number of primary care physicians per 100,000 population.

Research has shown that prevention is an effective tool to keep people healthy. People participating in early screening programs have increased but the majority of screenings have not met the Healthy People 2010 goals. The only testing indicator reaching the Healthy People 2010 goal is Pap Testing, with 94% of women indicating in the 2008 NYSDOH survey that they had ever received a pap test.

Access to Quality Care Utilization

Category	Percentage
Have Health Insurance	89
Have Primary Care Provider	89
Health Status Good or Better	86
Had Teeth Cleaned	72
Visited Doctor	71
Seen Dentist Past Year	70
Delayed Care Due to Cost	11

Percentage of Adult Respondents

Access to Quality - Preventive Testing

Category	Percentage
Pap test (women)	94
Cholesterol Test	80
PSA Screening (men age 40 and older)	68
Mammogram (women)	66
Digital Rectal Exam (men)	43
Home Blood Test (adults age 50 and older)	15

Percentage of Respondents
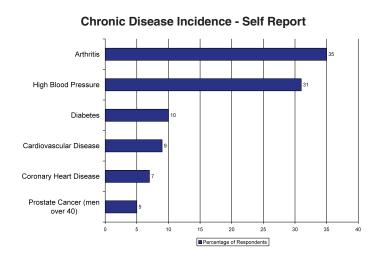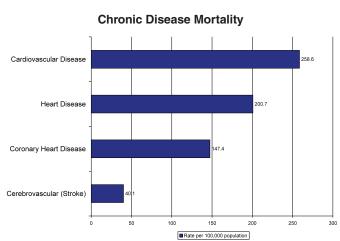
Caring for the elderly and disabled persons will continue to grow as a regional issue as the population ages. In the Adirondack region there are eighteen (18) nursing homes in five-counties with a total of 2,455 available beds (Hamilton County has no nursing homes). While there are negligible geographic variations in nursing home occupancy rates in the six-county Adirondack Region, the overall occupancy rate of 94% could indicate a potentially growing barrier to access. Affordability of long term care is also a concern in the region, where the average cost of care is estimated at $93,192 per year.
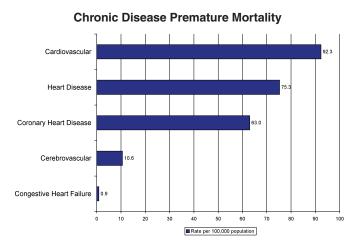
In the 2004/07 ARHN survey, 12% of respondents also indicated that they were the caregiver for a disabled or elderly person who required special care. While the majority (73%) of respondents who are caregivers are able to have the necessary care received within their home, this also suggests that additional supports may be needed for the remainder of the population (27%) who do not. Of those indicating they did not feel the person in their care was receiving the care they need, 25% indicated they "cannot find the services" and 31% indicated it was because of "cost, no insurance coverage or only partial coverage." Additionally, as reported in the Unintentional Injury section of the report, fall related hospitalizations for persons age 65+ is 203.5 per 10,000 population, higher than the state average of 196.
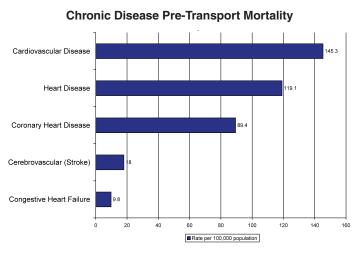
Chronic Disease

A significant percentage of the population suffers from any one of a number of conditions, and many people suffer from multiple conditions. There are diseases that do not always provide much warning and when there are warning signs they are often ignored until it is too late, as evidenced by higher than average rates of premature and pre-transport mortality.

Chronic Disease Incidence - Self Report

Condition	Percentage of Respondents
Arthritis	35
High Blood Pressure	31
Diabetes	10
Cardiovascular Disease	9
Coronary Heart Disease	7
Prostate Cancer (men over 40)	5

Chronic Disease Mortality

Condition	Rate per 100,000 population
Cardiovascular Disease	258.6
Heart Disease	200.7
Coronary Heart Disease	147.4
Cerebrovascular (Stroke)	40.1

Chronic Disease Premature Mortality

Condition	Rate per 100,000 population
Cardiovascular	92.3
Heart Disease	75.3
Coronary Heart Disease	63.0
Cerebrovascular	10.6
Congestive Heart Failure	0.9

Chronic Disease Pre-Transport Mortality

Condition	Rate per 100,000 population
Cardiovascular Disease	145.3
Heart Disease	119.1
Coronary Heart Disease	89.4
Cerebrovascular (Stroke)	18
Congestive Heart Failure	9.8

In terms of cancer incidence, the averages for the ARHN region are fairly similar to the Upstate averages although there were three cancers where the incidence was higher than average in four or more counties. The cancers are cervical, malignant mesothelioma and oral cavity and pharynx cancer. The cancers with the highest incidence for the ARHN region on average were prostate cancer at 160.3 per 100,000 residents and female breast cancer at 124.9 per 100,000 residents.

In terms of cancer mortality, the ARHN region average was generally at or below the Upstate average with the exception of cervical cancer, where the ARHN average was 2.8 and the Upstate average was 2.2 per 100,000 residents. Prostate cancer had the highest ARHN region weighted mortality at 27.3 per 100,000 residents, followed by breast cancer at 23.5, colorectal at 19.1 and colon and rectum at 17.7.

Cancer Incidence Rates

Cancer	Rate per 100,000 population
Prostate	160.3
Female Breast	124.9
Colon and Rectum	50.8
Mesothelioma	17.8
Ovary	15.1
Oral Cavity and Pharynx	13
Uterine	8.5

Cancer Mortality

Cancer	Rate per 100,000 population
Prostate	27.3
Female Breast	23.5
Colorectal	19.1
Colon and Rectum	17.7
Ovary	9.2
Cervical	2.8
Melanoma of the Skin	2.5

Hospitalizations were below the Upstate average, especially for the most recent year's data (2006), which, coupled with the premature mortality statistics could suggest there is an increasing need for identification and management of chronic diseases. For those diseases where hospitalizations do occur, Cancer is the most urgent priority with Respiratory Disease, and Digestive Disease emerging. Although Urinary Disease is increasing, the volume of patients this represents is relatively small. Heart Disease hospitalizations, although not increasing, still affects a large number of patients in this region. Of less concern is Skin Disease which represents a small portion of the total patients and has been decreasing over time.

Community Preparedness

Overall, the data boasts that 100% of the six regional counties, as well as the state, have emergency preparedness plans, which indicates that the region is prepared for community disasters. However, only one in five (20%) respondents reported in the 2004/07 ARHN survey that they have received training in First Aid and/or CPR in the past two years.
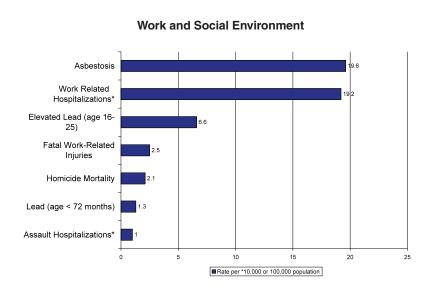
Additionally, while the majority (77%) of regional respondents indicated that they were satisfied with the emergency ambulance service available, transportation in the region continues to be a concern as evidenced by the regional pre-transport mortality statistics, as well as the discussion regarding the importance of transportation in the focus groups. Sixteen percent (16%) of regional respondents indicated that someone in their household had received emergency ambulance services in the past 12 months. When asked what time of day they had utilized the ambulance, the most frequent response was daytime, working hours, 8am-5pm (43%) followed by evening, 5pm-midnight (34%). Most regional emergency ambulance services received a satisfaction rating around the average of 65%.

Healthy Environment

A healthy environment is an important component of community health, and while focus group participants discussed the importance of Air and Water Quality to the health of the region, local and regional statistics on air and water quality are not available. Overall, 17% of the survey respondents in the region have been told they had asthma, which is equivalent to the state rate. A total of 12% of respondents in the 2008 survey also indicated that they currently have asthma, compared to a state rate of 10%, which is consistent with rates in the earlier (2004/07) survey.

The CHA data indicates that on average the ARHN region has much better rates than Upstate New York, New York State, and the United States. The ARHN average is well within the New York State 2013 goal for asthma hospitalizations at 12.4 per 10,000 residents and the region essentially meets the goal for asthma hospitalizations for age 0-17, at 17.4 per 100,000 residents.

In terms of other healthy environment indicators in the Community Health Assessment (CHA) data, the ARHN region was generally better than Upstate and state averages, with two exceptions – elevated lead levels age 16+, and asbestosis hospitalizations age 15+.

Work and Social Environment

Indicator	Rate per *10,000 or 100,000 population
Asbestosis	19.6
Work Related Hospitalizations*	19.2
Elevated Lead (age 16-25)	6.6
Fatal Work-Related Injuries	2.5
Homicide Mortality	2.1
Lead (age < 72 months)	1.3
Assault Hospitalizations*	1

Healthy Mothers, Healthy Babies, Healthy Children

Overall, the health of mothers, babies and young children is generally good in the ARHN region. Wellness, particularly of children and youth are important to regional residents, who rated this topic as one of the highest priorities in the focus groups. There are very few indicators of maternal/child health where the weighted average for the ARHN region exceeded the Upstate average. Exceptions included some of the oral health measures and the gastroenteritis hospitalization rate for the 0 - 4 age group. There were 22.7 hospitalizations per 10,000 residents on average in the ARHN region, as compared to a 16.9 hospitalization rate for young children with gastroenteritis in Upstate New York. There also were two measures of infant mortality where the regional average exceeded the Upstate average. One was fetal death >20 weeks gestation and the other was post-neonatal death for infants age 1 month to 1 year.

While only about 1% of the women participating in the 2004/07 survey indicated that they were currently pregnant, most women (93%) indicated that they saw a physician during their first trimester and (72%) of the women with children indicated that they had breastfed their last child. While these self reported statistics appear positive, the CHA data indicates that only 77% of regional woman actually received pre-natal care during their first trimester.

Teen pregnancy rates in the ARHN region also compare favorably to Upstate and state rates. When compared to total live births regardless of age, 1.4% of total live births for the ARHN region were to teenagers compared to 2.1% of the total number of live births for the state. Teenage pregnancy rates for females age 15-19 per 1,000 females for the ARHN region were 37.7 compared to 61.3 for the State.

For hospitalization rates within the Healthy Mothers, Healthy Babies and Healthy Children category, Female Reproductive problems are of highest priority, which relates to the breast and cervical cancer rates highlighted in the Chronic Disease section. Congenital Anomalies and Complications of Pregnancy are emerging as serious issues due to the large number of patients affected and increasing occurrences.

Infectious Disease

Tracking and preventing Infectious Diseases is an important public health priority and in 2009, public health officials are preparing for the upcoming flu season where H1N1 influenza is expected to be an important issue. In the 2008 survey, almost half (42%) of regional respondents report having had a flu shot in the past 12 months, which is equal to the state rate. These are also comparable to the rates from the 2004/07 ARHN survey. Almost a third (30%) of respondents in the ARHN region report having had a pneumonia shot. This is somewhat higher than the state rate of 26%. The majority of respondents (74%) who were adults age 65 and over reported they had a pneumonia shot. This is higher than the state rate of 64%. The hospital utilization rates for infectious and parasitic diseases has increased in the region over the past 6 years to almost 30 per 10,000 residents, driven mostly by inpatient utilization rates that have increased, highlighting the importance of prevention in this area.

Of the 13 CHA indicators for Infectious and Contagious Diseases, four indicators for the ARHN region exceeded the Upstate average including Pertussis, Pneumoconiosis age 15+, E. Coli, and Hepatitis A. None of those are New York State Department of Health Prevention Agenda priorities. While sexually transmitted diseases are also tracked and reported, many compare favorably to upstate and state averages.

Mental Health and Substance Abuse

Mental health and substance abuse-related issues are increasing in importance in the region, as evidenced by higher than average rates for a number of indicators and the focus group discussions related to the importance of prevention and treatment programs. The ARHN average exceeded the average for Upstate New York in seven out of the nine indicators including suicide mortality, adults that binge drink, alcohol-related motor vehicle injuries and deaths, cirrhosis mortality, self-inflicted injury hospitalizations, cirrhosis hospitalizations and self-inflicted injury hospitalizations age 15-19. The ARHN suicide mortality rate of 10.3 per 100,000 residents was over twice the New York State 2013 goal of 4.8. Hospitalization rates for psychoses, other mental health and drug and alcohol-related conditions have increased over the last few years.
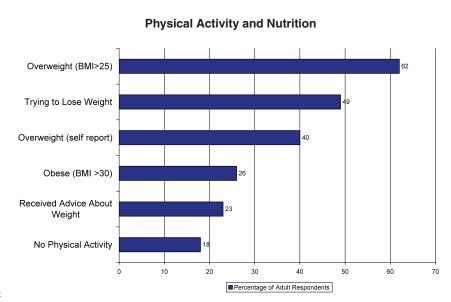
In addition to the incidence statistics, behavioral risk factors also illustrate the importance of prevention and intervention in this area including:

- In the 2004/07 ARHN survey, about 17% of respondents indicated that they felt sad, blue or depressed for two consecutive weeks and 12% reported that they have depression or other mental health problems. Thirteen (13%) of regional respondents indicated that they had sought help from a health professional for stress, depression or emotional problems in the past 12 months and 13% also indicated that they delayed getting the mental health they needed. In the 2008 Survey, a slightly higher percentage (12%) of respondents reported having poor mental health 14 or more days within the past month, comparable to the state rate of 10%.

- When looking at either poor physical or mental health, 19% of regional respondents indicated that they had poor physical or mental health 14 or more days within the past month, compared to a state rate of 18%.

- The majority of respondents (51%) in the 2004/07 ARHN survey indicated that they drank alcohol at least once in the last 30 days. Almost a quarter (23%) of respondents in the 2008 NYSDOH survey indicated that they have binge drank in the past month. This is slightly higher than the state average of 20%. About 9% of respondents indicated that they have participated in heavy drinking in the past month, a statistic that is consistent throughout the region. The state average is 5%. In the 2004/07 ARHN survey, 12% of respondents indicated that they had driven a vehicle after drinking in the past 12 months.

Physical Activity and Nutrition

The relationship between nutrition, obesity and disease incidence makes physical activity and nutrition an important priority for the ARHN region, particularly when looking at the regional indicators. Only a little more than a quarter (28%) of adults in the ARHN region report that they eat 5 or more servings of fruits and vegetables a day, compared to a state rate of 27%. In the 2004/07 ARHN survey, 36% of respondents indicated that they ate one to two fast food type meals in the last seven days, although the majority (55%) had not eaten any fast food type meals in the last seven days. The majority of the respondents (62%) would be classified as either overweight or obese, as defined by a Body Mass Index of 25.0 or greater. This is slightly higher than the state rate of 58%. About a fourth (23%) of regional respondents indicated that they received advice about their weight from a health professional, compared with the state rate of 28%. Of those who were given advice about their weight, the majority (88%) were advised to lose weight which is consistent with the state average.

Physical Activity and Nutrition

Category	Value
Overweight (BMI>25)	62
Trying to Lose Weight	49
Overweight (self report)	40
Obese (BMI >30)	26
Received Advice About Weight	23
No Physical Activity	18

■ Percentage of Adult Respondents
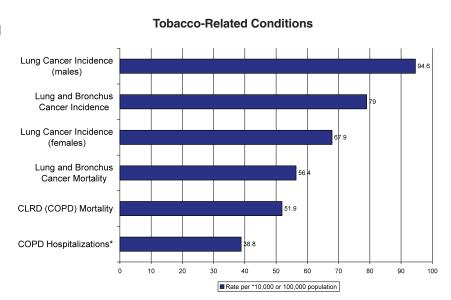
The highest number of priority votes for interventions generated from focus group discussions pertained to physical activity/nutrition and involved recommendations for school districts. Several of these suggestions are for programs specifically geared toward youth recreation and teaching healthy lifestyles and nutrition. Top themes were also related to promoting wellness and prevention, as well as food and eating habits.

Tobacco Use

While the majority (77%) of regional survey respondents indicated that they prohibit smoking in their homes, Tobacco Use continues to be a priority in the ARHN region, as evidenced by higher than average smoking rates and higher than average incidence rates for smoking-related diseases. About one in five (22%) ARHN respondents reported in 2008 that they smoked everyday or some days, which was higher than the 17% reported at the state level.
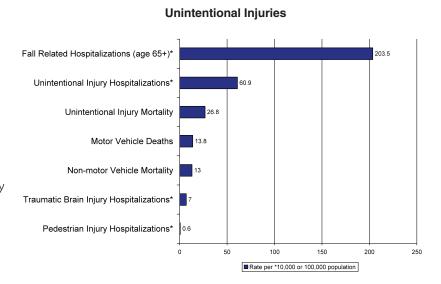
Of the six CHA Indicators for tobacco-related disease incidence, hospitalization, and mortality, the ARHN weighted average exceeded the Upstate average on five of the six indicators, including lung cancer for males and females, lung and bronchus cancer incidence, CLRD (COPD) mortality, and lung and bronchus cancer mortality.

Tobacco-Related Conditions

Condition	Value
Lung Cancer Incidence (males)	94.6
Lung and Bronchus Cancer Incidence	79
Lung Cancer Incidence (females)	67.9
Lung and Bronchus Cancer Mortality	56.4
CLRD (COPD) Mortality	51.9
COPD Hospitalizations*	38.8

■ Rate per *10,000 or 100,000 population

Hospital utilization rates for Trachea/Lung malignant neoplasms are increasing slightly in the ARHN region from a rate of 8 per 10,000 residents to 10 over the past 6 years. Inpatient utilization has remained stable, while ambulatory surgery is increasing somewhat.

Unintentional Injury

Fall-related hospitalizations for persons 65+ is the highest priority related to unintentional injury of the indicators listed with a rate (203.5 per 10,000 population) that is higher than the NYS average of 196, and significantly higher than the state goal of 155 per 10,000.

In the 2008 NYSDOH survey, 19% of regional respondents indicated that they had a fall within the past three months, compared to a state rate of 14%. A small percentage of respondents (4%) at both the regional and state levels indicated they were injured by a fall.

Unintentional Injuries

	Rate per *10,000 or 100,000 population
Fall Related Hospitalizations (age 65+)*	203.5
Unintentional Injury Hospitalizations*	60.9
Unintentional Injury Mortality	26.8
Motor Vehicle Deaths	13.8
Non-motor Vehicle Mortality	13
Traumatic Brain Injury Hospitalizations*	7
Pedestrian Injury Hospitalizations*	0.6

Additionally, the New York State Department of Health Prevention Agenda priority indicators of concern in the ARHN region include Unintentional injury mortality and motor vehicle deaths. Motor vehicle deaths for the ARHN region (13.8 per 100,000) are significantly higher than the Upstate average and over twice the New York State 2013 goal of 5.8 per 100,000 residents.
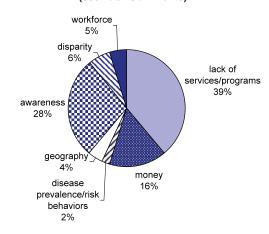
Hospitalizations for all types of unintentional injuries have been increasing with the general category of Other Injuries being of highest priority. This category includes a wide range of injuries not included in the other groups. Poisoning injuries are increasing rapidly and emerging as a priority. The Volume of Fractures remain stable, but is a significant portion of the injuries reported.

Community Input/Participation

In addition to the five quantitative data sets analyzed, focus groups were conducted from November 2008 through May 2009. There were 24 groups convened throughout the six-county region with a total of 286 participants. When asked to describe their vision for a healthy community, participants described community health in its broadest terms, recognizing that many elements are outside of the traditional public health and health care systems. Education, transportation and infrastructure, safety, housing and crime prevention are all integral components of a healthy community in addition to health insurance, access to care, affordablilty, wellness and other traditional elements of a health care system.

ARHN Community Health Assessment Barriers (369 Total Comments)

- workforce 5%
- disparity 6%
- awareness 28%
- geography 4%
- disease prevalence/risk behaviors 2%
- money 16%
- lack of services/programs 39%

During the focus groups, participants were asked to identify barriers to creating a healthy community. As shown above, lack of services and programs (39%) was suggested to be the greatest barrier, followed by awareness (28%), money (16%), disparity (6%), workforce (5%), geography (4%), and lastly disease prevalence/risk behaviors (2%).
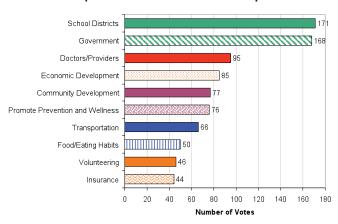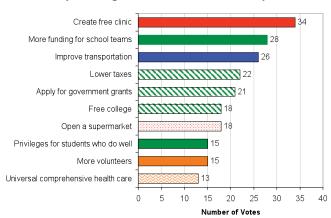
These barriers were categorized into themes with the top 10 themes illustrated below. Focus group participants were then asked to discuss and vote on priority items for creating a healthy community. The top suggestions are illustrated below. The bars are coded based on the theme they belong with. Ideas include creating a free clinic, more funding for school programs, and improving transportation. Three of the suggestions fall under government, two relate to school districts, and the other ideas are each related to one of the themes.

Top 10 Themes from Focus Groups

Theme	Number of Votes
School Districts	171
Government	168
Doctors/Providers	95
Economic Development	85
Community Development	77
Promote Prevention and Wellness	76
Transportation	66
Food/Eating Habits	50
Volunteering	46
Insurance	44

Top 10 Single Items from Focus Groups

Single Item	Number of Votes
Create free clinic	34
More funding for school teams	28
Improve transportation	26
Lower taxes	22
Apply for government grants	21
Free college	18
Open a supermarket	18
Privileges for students who do well	15
More volunteers	15
Universal comprehensive health care	13

Of the prevention agenda indicator areas, the majority of votes generated from focus groups related to physical activity and nutrition. Recommendations involved school districts followed closely by governments. Among these recommendations were developing programs and community/policy initiatives that improve access to health and wellness, as well as food and eating habits.

Additional suggestions included lowering taxes, apply for government grants, increasing funding to support new air quality and water systems, offering free college, opening a supermarket, collaboration, and program development.

Access to care was another key area of discussion in the focus groups. The theme of Doctors/Providers (95) received a number of votes, along with ideas related to creating a free clinic, better access/more affordable health care, and availabilty and location of necessary medical services. The theme of transportation received a high number of priority votes (66) with the key single ideas noted related to improving transportation, with a focus on accessibility and affordability. Insurance (44) rounded out the top three, with the highest single item related to universal health care.

Of additional interest were the themes relating to Healthy Mothers, Healthy Babies, Healthy Children, which include Parenting/Family Education (36), Youth Services (34), and Youth Brain Drain (18). There is a perception that there is a lack of programs and services available for youth to support positive youth development and to ensure that young people stay within the ARHN region.

Ideas related to Alcohol/Substance Abuse (20), and Mental Health (13) priorities were also discussed and identified in the focus groups. Participants highlight the need for increased services and programs to address alcohol and substance abuse problems and issues.

Strategic Priority Health Issues

In June 2009, based on the information gathered in this community health assessment, the community service plan, and the guidelines set forth in the New York State Prevention Agenda and Healthy People 2010, the Committee convened to discuss and analyze all of the health indicator information contained in the study. They also engaged in a best practice priority setting process to determine the top priority health issues.

The criteria ranking of the ten health priority areas were very close. In order to be precise in their decision-making the Committee completed a paired comparison exercise. In this exercise the Committee compared the top six health areas against each other, determining the higher priority area in each case. The results of all the paired comparisons were tallied and the scores added to the overall priority ranking to determine the final list of the top six priority health areas for the ARHN region, with Physical Activity and Nutrition topping the list.

Criteria Ranking

Prevention Agenda Areas	Score
Tobacco Use	72.75
Community Preparedness	59.45
Physical Activity & Nutrition	58.78
Chronic Disease	57.05
Infectious Disease	56.12
Access to Quality Health Care	54.72
Healthy Mothers, Healthy Babies & Healthy Children	50.55
Healthy Environment	47.68
Mental Health & Substance Abuse	44.35
Unintentional Injury	40.87

Criteria Ranking Plus Paired Comparison

Prevention Agenda Areas	Score
Physical Activity & Nutrition	76.8
Chronic Disease	66.3
Access to Quality Health Care	61.1
Tobacco Use	40.0
Community Preparedness	27.4
Infectious Disease	27.4

Regional Action Plan

While the Committee members agree to focus on Physical Activity and Nutrition as a regional priority issue, individual organizations will each have additional priority health issues to focus on over the next few years. It is likely those priorities will be drawn from the list of the top six regional priorities as presented above; however, any of the ten Prevention Agenda areas could be selected.

The following physical activity and nutrition outcomes were identified by the Committee as steps to be taken over the next three years:

Outcome 1: Establish a taskforce of regional representatives whose goal is to select activities, design an implementation schedule and select a method of evaluation for evidence-based programs focusing on physical activity and/or nutrition by January 1, 2010 for Year 2 and 3 implementation.

Outcome 2: Develop a workplan with measurable outcomes, implementation schedules and budgets by June 30, 2010.

Outcome 3: Physical activity and/or nutrition interventions are implemented by taskforce members by June 30, 2011.

Outcome 4: Physical activity and/or nutrition interventions are evaluated and results are communicated to stakeholders by June 30, 2012.

History and Accomplishments

Managing the Ongoing Community Health Assessment Process

Established in 1992 through a New York State Department of Health Rural Health Network Development Grant, the Adirondack Rural Health Network (ARHN) is a community partnership of public, private and non-profit organizations in Upstate New York. ARHN links local public health departments, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations by creating a collaborative process for developing strategies and for implementing, monitoring and evaluating the regional health care system. The Upper Hudson Primary Care Consortium, a 501-c-3 corporation licensed as an Article 28 Central Service Facility, serves as host organization for ARHN and provides financial management, human resources, and information technology support.

Since 2002, the ARHN has been recognized as the leading sponsor of formal health planning for Essex, Fulton, Hamilton, Saratoga, Warren and Washington counties. Together with community stakeholders, the ARHN has developed and implemented a sophisticated process of community health assessment for the defined region. The first ARHN regional community health assessment report was released five years ago, in September 2004. Subsequent to the report's release, ARHN staff, county health directors and staff, hospitals and community-based stakeholders have continued to meet on a regular basis. Together, they exchange information, plan new initiatives, and develop strategies to produce an ever-current picture of the health care landscape that can be used by stakeholders throughout the region.

Following is a summary of the general Community Health Assessment (CHA) related data management and public information activities that the ARHN has been involved in, beginning with 2005.

2005 ARHN CHA-Related Activities

- County Health Departments submit 2005-2010 Community Health Assessment reports using data from the 2004 regional report

- CHA data collection and analysis continues

- CHA data is used for grant writing and work plan development

- Priority health concerns are incorporated into the ARHN work plan

- County Health Departments discuss with the ARHN the potential to provide Article 6 funding to support on-going community health assessment activities

- ARHN secures funding to develop an expanded ARHN website

- A quarterly reporting system is initiated to track use of the ARHN website

- Albany Medical Center, Hudson Mohawk Area Health Education Center, Mountain Lakes Regional EMS Council and ARHN combine resources to develop a new website for the recruitment and retention of emergency care providers: http://nyemtinfo.com

2006 ARHN CHA-Related Activities

- ARHN completes their improved and expanded website: http://arhn.org
- Fulton County Public Health joins the ARHN, increasing the network to 6 counties
- "Find a Dentist" tool is added to the ARHN website—a searchable tool for locating dentists in the region
- ARHN participates in the NYS Community Assessment Impact Group
- County Health Departments receive approval to commit financial resources to support the ARHN to facilitate regional community health assessment activities

2007 ARHN CHA-Related Activities

- Contracts with County Health Departments executed and new data work begins
- Telephone survey completed in March 2007 for 300 households in Fulton County and 300 in southern Saratoga County; data is analyzed and posted to the ARHN website
- On-line data query tool developed, tested and released to community
- Community health priorities summary of activities project begins

2008 ARHN CHA-Related Activities

- Funding for CHA activities secured from a variety of county, regional, and state partners
- Adirondack Rural Health Network Community Health Planning Committee convenes regularly to determine goals for 2008, steps needed to focus the assessment strategy, and further enhance the ARHN.org website
- Demonstration of the ARHN regional CHA work, the ARHN.org website, and its online data query tools provided to NYSDOH Commissioner, Richard F. Daines, M.D.
- Developed user guide for online data query tools and completed a major redesign of the ARHN.org layout to make it easier to use and to expand in the future
- Collaborated with the Center for Health Workforce Studies in a study of physician supply and access to health care in the region, relying in large part on the ARHN CHA survey of over 1,200 households
- Identified training needs and completed training sessions on data synthesis and on managing focus group meetings

Addressing 2004 Community Health Assessment Priority Issues

In 2004, after review of a considerable amount of data and other evidence, the Adirondack Rural Health Network Community Health Planning Committee (the Committee) determined there were two main categories of health issues that were of most concern in the region, namely:

- **Access to Quality Health Services**
- **Health Promotion for Disease Prevention**

To develop actions and create partnerships for addressing these priority categories, the Committee identified the specific aspects of Access and Prevention that were of most concern. The goal was to clarify specific health issues within these main categories so that stakeholders and other community members could easily address the issues.

The nine specific issues identified by the Committee are listed under the two main categories, as follows:

1. Access to Quality Health Services

- Emergency Medical Services
- Health Insurance
- Long Term Care Options
- Mental Health Services
- Oral Health and Dental Care

2. Health Promotion for Disease Prevention

- Alcohol and Substance Abuse
- Early Detection of Cancer and Other Disease
- Nutrition and Fitness
- Tobacco Use

The 2004 ARHN CHA document outlines all of the data and evidence that led to those issues being identified as the highest priorities. This document is available online at http://www.arhn.org/regional-health-assessment.php.

Since 2004, ARHN staff and the Committee members have been involved in a number of activities to cooperatively address the priority issues. A compilation of all the projects and activities would result in a lengthy report. Thus, we have chosen to include brief summaries of activities, as outlined below.

Emergency Medical Services

Emergency Medical Services (EMS) is the umbrella term for a continuum of health services including pre-hospital medical care, emergency services provided at the hospital or health center and a trauma system that often serves as the network of coordinated care.

Many communities in the ARHN region are a 55-minute (one-way) ambulance ride to the nearest hospital. Five of the community health focus groups identified EMS as a priority health issue, with a shortage of volunteers being the main problem mentioned.

Initiatives ARHN committee members have been involved with:

- Emergency Medical Services Regional Council
- Emergency Response and Disaster Preparedness
- EMS Recruitment, Retention and Training
- Recruitment, Retention and Education Website
- Community Education
- Distribution of Educational Materials and Publications

Health Insurance

In 2004, 12% of the telephone survey respondents reported not having health insurance. About one-third (34%) of those who delayed getting care for a medical problem reported that lack of insurance was the primary reason.

Initiatives ARHN committee members have been involved with:

- Identification and Referral
- Facilitated Enrollment Program
- Sliding Fee Scale
- Outreach Services for Under and Non-Insured Families
- Early Intervention: Children with Special Health Care Needs
- Medical Obstetrical Maternal Services (MOMS)

Long Term Care

By the year 2030, it is projected that the elderly population will double and one-fifth of the US population will be over the age of 65. Nearly 22% of the nation's elderly reside in rural areas and approximately 75% of those over 65 suffer from at least one chronic illness. It is estimated that by 2010, nearly 20% of the people living in the ARHN area will be 65 years and older.

Initiatives ARHN committee members have been involved with:

- Identification and Referral
- Long Term Care Council
- Provision of Services
- Provider Education
- Community Education
- Distribution of Educational Materials and Publications
- Database and Resource Directory Development

Mental Health Services

Mental illness, addictive disorders, and suicide are serious health challenges in the region. Almost one-fifth (19%) of the ARHN survey respondents in 2004 reported feeling sad, blue, or depressed for two weeks or more in a row during the past 12 months.

Initiatives ARHN committee members have been involved with:

- Identification and Referral
- Pre and Post Partum Depression Screening
- Community Education
- Provider Education
- Distribution of Educational Materials and Publications
- Mental Health Professional Shortage Area Designation (HPSA)

Oral Health and Dental Care

In 2004, approximately 23% of households in the ARHN service area had children who had not received a dental exam outside of school. One-half of adults did not have dental insurance and one-quarter (26%) of adults did not get the dental care they think they needed.

Initiatives ARHN committee members have been involved with:

- Dental Professional Shortage Area Designation (HPSA)
- Dental Recruitment Assistance
- Well Child Fluoride Program
- Expanded and New Dental Clinic Capacity
- Database and Resource Directory Development
- Oral Health and Dental Care Education
- Distribution of Educational Materials and Publications
- Creation of the Smile Coalition
- Local and State Advocacy

Alcohol and Substance Abuse Prevention

In 2004, on virtually every measure of alcohol use and abuse, the ARHN counties exceeded the NYS average by a considerable degree. The rate of intoxicated youth involved in auto accidents in the ARHN service area was almost three times the NYS average.

Initiatives ARHN committee members have been involved with:

- DWI Prevention Program
- Underage Drinking Prevention
- Educational Outreach
- Referral Services
- Distribution of Educational Materials and Publications
- Social Marketing Campaigns

Early Detection of Cancer and Other Diseases

As reflected in data collected in 2004, 105 women in the ARHN area died from lung and bronchus cancer each year, indicating a mortality rate that is much higher than the NYS or national averages. Almost one-third (30%) of all cancer deaths, including 87% of lung cancer deaths, could be attributed to tobacco. Overweight & obesity could account for 14% of cancer deaths in men and 20% of cancer deaths in women.

Initiatives ARHN committee members have been involved with:

- Healthy Living Partnership Breast, Cervical, and Colorectal Screenings
- Diabetes Coalition
- HIV/AIDS/STD Testing and Counseling
- Hepatitis B Prevention
- Tuberculosis Screening
- Infectious Disease Control Programs
- Free Immunization Programs

- Referral Services
- Professional In-service Education
- Community Based Education
- Distribution of Educational Materials and Publications
- Database and Resource Directory Development
- Social Marketing

Nutrition and Fitness

In 2004, obesity, diet and diabetes were identified as priority health issues in four local community health focus groups, while health professionals in the area viewed obesity and diabetes as serious problems. The measure of Body Mass Index (BMI) calculated on the 1,336 survey participants who provided their height and weight confirmed that the problem of obesity in the ARHN service area exceeded the extent of the problem nationally.

Initiatives ARHN committee members have been involved with:

- School-based Nutrition and Fitness Programs
- Home-based Nutritional Guidance Programs
- Community Education

- Distribution of Educational Materials and Publications
- Social Marketing Campaigns
- Stakeholder Interviews

Tobacco Use

In 2004, the average percentage of adults who smoked in the ARHN area appeared to be within the national average, although use of tobacco was more prevalent in some localities. For example, smoking – including teen smoking – was identified as a priority health issue in the community focus groups in the Essex County towns of Port Henry and Willsboro and Blue Mountain Lake in Hamilton County.

Initiatives ARHN committee members have been involved with:

- School Based Programming
- Community Education
- Smoking Cessation Programs
- Referral Services

- Distribution of Educational Materials and Publications
- Social Marketing Campaigns
- Database Resource Directory

Other Accomplishments Since 2004

Since publishing the regional CHA in 2004, the information has leveraged approximately $5.7 million in community health-related funding for the region, including:

- Consolidated Health Center Programming
- Consolidated Health Center Program New Access Point Funding for a Federally Qualified Health Center
- A USDA Distance Learning & Telemedicine Grant
- Funding to develop an Online Data Query System
- Funding to facilitate formal, structured discussions on key topics such as health literacy, migrant health, oral health, and behavioral health

The CHA data and report also allowed regional stakeholders to develop new partnerships and leverage additional funding, including:

- A National Association of County and City Health Officials planning grant for the integration of Public Health, Primary Care and Mental Health
- New York State Department of Health Rural Health Network funding
- Contract with the Center for Best Practice for the Prevention of Childhood Overweight and Obesity to conduct a community needs assessment
- A New York State Office of Mental Health Geriatric Mental Health Demonstration Project
- NYS Department of Transportation Section 5310 Bus Grant Award
- New York State Office For Aging Community Empowerment for Aging in the Community Planning Grant

Lessons Learned and Implications for 2010-2013 Community Health Assessment Activities

Although the Community Health Assessment document is requested by the New York State Department of Health (NYSDOH) on a regular basis, the process of addressing community health issues is on-going. The success of that process rests on the dedication and cooperation of a number of health care providers, key community leaders, human service providers and individuals serving in the public health professions. After seven years of on-going community health planning, the ARHN has learned the following:

- Data collection is important but in many ways it is the underlying process of coming together for collective action that makes a project successful
- Leadership is essential – invest time to nurture relationships and develop consensus
- There is no simple and speedy detour to translate identified goals into implementation
- Partnerships can help to eliminate health disparities by moving communities from statistics to solutions
- Effective use of data leads people to a deeper understanding of how an issue is relevant to their lives

In 2009, the Committee was re-energized with the increased involvement of representatives from each of the hospitals in the ARHN region. Their active involvement allowed the Committee to expand its research and analysis to include more hospitalization data. The hospitals' involvement also resulted in a robust priority setting process that addressed both the needs of the county public health departments and their required CHA documents, as well as the needs of the hospitals and their required Community Service Plans (CSPs). As a result, the public health departments and

the hospitals will work together to address priority health issues of mutual concern, seeking both to address those conditions that result in the greatest morbidity, mortality, disability, and years of productive life lost, as well as those health issues of greatest concern to local communities.

There are additional outcomes anticipated by the Committee that will promote a better understanding of health and quality of life issues that will move from data awareness to effecting well-informed community change. Based on the experience gained in the past seven years, the ARHN anticipates these additional outcomes:

- Increased Local and Regional Capacity

- Better Access to Timely Data

- Additional Regional Training and Technical Assistance

- Increased Leveraging of Local and Regional Funding

- Collaborative Problem-Solving

- Developing and Evaluating Programs that Effect Regional Priorities

Project Direction

Building a Healthy Community: Healthy Assessment and Community Service Plan is a project of the Adirondack Rural Health Network funded by state and county government, foundations, hospitals, community based organizations and rural health network grant funding from the New York State Department of Health. We acknowledge the expertise of Strategy Solutions, Inc. and Holmes & Associates in assisting in conducting the study. We appreciate the support of the many groups and agencies that responded to our call for data.

This study has been made possible through the collaboration among many organizational leaders from the six-county region. In acknowledgement of their commitment to the health of community residents and their diligent efforts for providing financial support, oversight and guidance, the following individuals and organizations comprise the Adirondack Rural Health Network Community Health Planning Committee (the Committee):

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FINANCIAL CONTRIBUTORS

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Essex County Health Department
Fulton County Public Health
Glens Falls Hospital
Greater Adirondack Perinatal Network
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Hudson Mohawk Area Health Education Center
Moses-Ludington Hospital
Nathan Littauer Hospital and Nursing Home
Saratoga County Public Health Nursing Service
Saratoga Hospital
School Beat Healthy Heart Program
Sexual Trauma and Recovery Services
The Glens Falls Foundation
Warren County Health Services
Washington County Public Health**
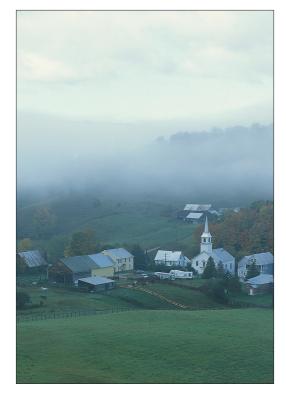
Project Overview

Overview of the Community Health Assessment and Planning Process

A Community Health Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in a defined region. Subsequently, this information may be used to formulate strategies to improve community health and wellness.

A hospital's Community Service Plan is a report to the community about the following:

- The hospital's mission
- The hospital's service area
- How the public participated in the planning process
- Public health priorities
- Action plans to address the priorities
- Financial aid programs
- Changes impacting community health
- Provision of charity care
- Access to services

In New York State, the Department of Health (NYSDOH) requests that, on a regular basis each county prepare a Community Health Assessment (usually every four years) and each hospital prepare a Community Service Plan (usually every three years).   The Community Health Assessment, or CHA, identifies those health issues of most concern in the county. For both the CHA and the Community Service Plan (CSP), certain issues are selected as priority health concerns. For those priority health concerns, additional details are provided, additional data collection occurs, stakeholders are identified and invited to participate, and action items are formulated. Progress is charted over the next few years and reported in successive CHA and CSP documents.

Counties and hospitals are encouraged to work together on their CHA and CSP documents to achieve economies of scale and other efficiencies by pooling their efforts and collecting much of the data that they need as a group, rather than each individual county and hospital trying to find and access the same sets of data. In 2003, the ARHN began facilitating the cooperative CHA activities of five counties: Essex, Hamilton, Saratoga, Warren and Washington. In 2007, Fulton County joined the cooperative effort, bringing to six the number of counties working together on the ARHN Regional Community Health Assessment.

In 2009, to support the New York State Commissioner of Health's statewide mission to improve the health of all New Yorkers, partners in the ARHN area came together to participate in this new public health initiative. This initiative seeks to integrate traditional medical services with public health interventions that stimulate positive behavioral changes to improve health status.

Facilitated by the ARHN, regional hospitals and counties participated in a collaborative approach to community health assessment and planning, and began to document those efforts in their CHAs and CSPs. ARHN members worked together to address the Commissioner's public health priorities identified in the Prevention Agenda Toward the Healthiest State. By participating in this public health effort, the counties and hospitals support the overall goals of the NYSDOH which are to focus on primary/secondary disease prevention, promote access to quality health care services and eliminate health care disparities where they exist.

As the facilitating agency, ARHN provides a forum where the community partners come together to effectively collaborate and to provide resources for the development of each county's Community Health Assessment and each hospital's Community Service Plan.
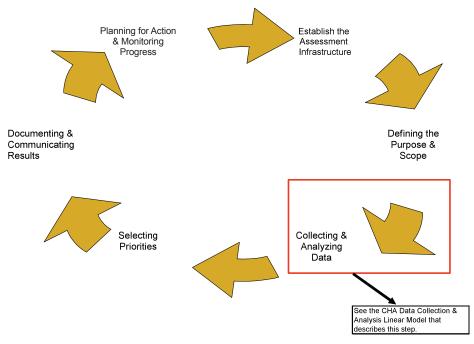
Between planning periods, new health issues can arise, a serious disease outbreak can occur, or a county may have an emergency situation. Rather than being a distinct activity that occurs only at specific points in time—for example, once every four years—the Community Health Assessment and the Community Service Plan in the Adirondack area is an ongoing process.

Diagram 1 is adopted from the Association for Community Health Improvement model and shows the process, beginning with establishing the infrastructure (meeting locations, schedule, staff, etc.) and defining the purpose and scope of the current CHA and CSP.

The core of the CHA and CSP Process is ***Collecting and Analyzing Data.*** This process helps the Committee identify what the data are indicating as the health issues of most concern. These findings are usually the basis for subsequent priority setting, gap analysis, identification of additional data needs, the setting of action items, and the development of monitoring procedures to measure change over time. Those steps then complete the CHA and CSP process.

Diagram 1

COMMUNITY HEALTH ASSSESSMENT CORE PROCESS STEPS

Given the importance of collecting and analyzing data to the entire CHA and CSP process, and recognizing that it is a multi-year process rather than a unique activity that occurs periodically, **Diagram 2** expands data collection and analysis into six distinct activities. At any point in the process, each of the six data activities could be occurring simultaneously. At other times, the Committee and staff will focus on only one or two of the activities. Each of the six data collection/compilation activities can result in new information or new insights, and together, they help to illuminate the most pressing of our community health issues.

Diagram 2

A Linear CHA Model for the ARHN showing Annual, Concurrent Work under each of Six Main CHA Data Collection Activities

Review of NYS and Federal Health Priorities

NYS CHAI Data Compilation

Local / Regional Data Collection (surveys, focus groups, etc.)

Expert Opinion in the Region (stakeholder involvement, etc.)

Evaluation of Local / Regional Progress (report cards, etc.)

Data Analysis and Preliminary Findings

Year 1   Year 2   Year 3   Year 4

Every Four Years:

Synthesis of all the Information, with Interpretation and Prioritization by the Partners

CHA Report Prepared and a User-Friendly Summary Distributed to the Public

The county health departments, hospitals and other stakeholders need a wide array of comparative data and information to understand the breadth and depth of specific health issues and to be confident that the priority issues they have selected are the most pressing health issues in the county and/or region. An accurate measurement of an issue's current status is also needed to assess progress. Obtaining a variety of measurements for a given priority issue can provide guidance as to where and what type of programs, policies, marketing messages, etc. might be most effective.

It is important to recognize the distinction between a health indicator and a health issue. The health indicator is a statistic that provides a numeric value for a specific health-related occurrence. While health indicators are important for a number of reasons, data alone cannot solve health problems. To determine which health issues deserve the region's attention, informed and experienced people need to consider the indicators in relation to each other, as well as in relation to other sources of information on the demographic, social, environmental, and economic characteristics of the area.

Stakeholder involvement is a key step in the process of identifying priority health issues. A diverse group of health professionals, programs, advocacy groups, and others are addressing one or more community health issues in the region on a daily basis. Their insights, experiences and ideas have made significant contributions to the regional CHA and CSP process.

New York State Prevention Agenda

In 2008, New York State Health Commissioner, Richard F. Daines, M.D., released "The Prevention Agenda Toward the Healthiest State." In this document Dr. Daines states "The Prevention Agenda is a call to action to local health departments, health care providers, health plans, schools, employers and businesses to collaborate at the community level to improve the health status of New Yorkers through increased emphasis on prevention."

The Prevention Agenda identifies ten priorities for improving the health of all New Yorkers and asks communities to work together to address them.

- Access to Quality Health Care
- Chronic Disease
- Community Preparedness
- Healthy Environment
- Healthy Mothers, Healthy Babies, Healthy Children

- Infectious Disease
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

This study was designed around the Prevention Agenda rationale and will enable a more strategic establishment of priorities, develop interventions and commit resources to improve the health of individual communities and the region as a whole.

The regional Community Health Assessment and Community Service Plan is intended to be a tool toward reaching these Prevention Agenda goals:

- Improving residents health status, increasing their life span and elevating their overall quality of life
- Reducing health disparities among residents
- Increasing accessibility to preventive health services for all community residents
- Developing programs that use the best available evidence in selecting programs and actions that can address the Prevention Agenda priorities

Scope of Project

This comprehensive community health assessment and community service plan includes collecting and analyzing both qualitative and quantitative data. The data consists of demographics, health status, health care service utilization, health status indicators, community perception of key health care issues, and stakeholder perceptions of strengths, weaknesses, threats and opportunities. The aggregate data relevant to the region, individual hospitals, or individual counties will provide a foundation for developing collaborative work plans that will include best practices/strategies to improve health care delivery across the continuum of care.

The Committee convened regular meetings from August 2008 through August 2009 to strategically plan and execute the components of the regional plan.

The Committee developed and approved the study parameters; designed the data analysis methodology; trained and mobilized focus group facilitators; designed a regional report format that includes sections for regional and individual county conclusions; researched and determined format for placement of tables, charts and graphs; and developed a priority setting criteria matrix. The six hospitals assembled a subcommittee that convened monthly to discuss and design templates for its Community Services Plans.   Together, the Community Health Assessment and the hospital Community Service Plan will help to identify overlaps and gaps in coverage within the ARHN area.

This partnership also solidifies the synergistic relationship between key collaborators to work together:

- Identifying priority needs
- Planning for and evaluating new and expanded programs focused on priority needs
- Cataloguing existing health-related activities within the region
- Providing constituents with information on community health needs
- Providing needs assessment data for grant funding

Methodology

Our methodology in rendering a complete picture of the health of our communities and region include six key data collection and analysis components:

- The New York State Department of Health conducted an extensive Behavioral Risk Factor Surveillance Survey (BRFSS) in 2008. The BRFSS was conducted by telephone surveys and collected information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The data is used throughout this study.

- The 2004/2007 ARHN Household Telephone Survey Data

- County, region and state disease incidence and Healthy People 2010 goals

- New York State Prevention Quality Indicator data (PQI)

- Hospital utilization data from the Statewide Planning and Research Cooperative System (SPARCS)

- Stakeholder focus groups which provide personal perspective of individuals who have insight on the health of a community or the region. These individuals also provide suggested activities for improving the health of the region.

Community Health Planning Approach

In keeping with the New York State Commissioner of Health's statewide mission to improve the health of all New Yorkers, the Adirondack Rural Health Network's community health planning process is a significant step toward meeting this goal. This initiative brought hospitals, public health and other community partners together in a collaborative approach to:

- Conduct a six county Community Health Assessment

- Complete six hospital Community Service Plans

- Identify problems that affect the health of our residents

- Select and implement evidence-based programs that will focus on primary/secondary disease prevention

- Promote access to quality health care services

- Eliminate health care disparities

The community health planning process develops a system that is better able to meet the needs of our communities while avoiding duplicative efforts and achieving economies of scale. This process supports the goals of the Prevention Agenda by establishing regional priorities and committing to working together to achieve healthier communities.

Behavioral Risk Factor Surveillance Survey

The Expanded Behavioral Risk Factor Surveillance System (Expanded BRFSS) augments the Center for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) that is conducted annually in New York State. Expanded BRFSS is a random digit dialed telephone survey among adults (18 years of age and older) representative of the non-institutionalized civilian population within New York State. The goal of Expanded BRFSS is to collect uniform, county-specific data on preventative health practices, risk behaviors, injuries and preventable infectious diseases. Indicators assessed by Expanded BRFSS include tobacco use, physical activity, diet and use of cancer screening services and other factors linked to chronic diseases.

The Expanded BRFSS encompasses 58 areas, collecting information representative of the population for each of New York's 57 counties (excluding New York City) and New York City (as a single area). For each of the areas, the goal was to complete about 650 interviews. A standard questionnaire was developed and was used in all 58 areas. The period of data collection was July 2008 through June 2009. The Adirondack Regional Community Health Assessment and Community Service Plan is based on six months of weighted data (July through December 2008). It is anticipated that the full-year data report will be available in fall 2009.

Based on past analysis, NYSDOH expect the indicators generated from the first six months will be similar to the final 12 month estimates. However, because these estimates are based on a smaller sample size than estimates for the final report, particular attention should be paid to the confidence intervals. This is especially important when analyzing results for smaller sub-populations. The BRFSS data used in this report could have an indicator with a confidence interval as wide as plus or minus 15 percentage points and be based on as few as 25 respondents. The true value of the indicator is estimated to be anywhere within the range of the confidence interval. (New York State Department of Health).

ARHN Household Telephone Survey Data

In 2003, the ARHN recognized that community health information was not available at the local level for a number of health indicators such as access to health care, healthy behaviors, certain health conditions, and many other health issues of concern. The Committee decided that a telephone survey of households in the area was the most efficient and effective approach for identifying the health issues of most concern to residents in the ARHN area.

ARHN Telephone Survey:
150 Questions in 15 Sections
Geographic Location
Current Health Status
Health Care Access and Utilization
Workplace Injuries
Healthy Living
Tobacco Use
Emergency Medical Services
Screening and Testing
Oral Health
Infant, Children, and Youth
Women's Health Issues
Mental Health
Elderly and Those With Disabilities
Alcohol Consumption
Demographics

The Committee worked with Holmes & Associates of Saranac Lake to develop the questionnaire over an eight-month period in 2003. As the draft survey began taking shape, it was discovered that not every health-related question of interest could be asked in a brief telephone survey. The final survey was trimmed to 115 questions that could be answered in less than 20 minutes. The questionnaire was organized into 15 sections, so the Committee could better track the relevance and completeness of the information.

Many of the ARHN survey questions were similar to questions used in national and state health surveys such as the Behavioral Risk Factor Surveillance System (BRFSS). The Rural Healthy People 2010 priority issue areas also formed the basis of some questions used in the survey. Both of these linkages helped to maintain comparability between the ARHN data and similar data available at the county, state and national levels.

The Siena Research Institute administered the telephone survey. The Siena researchers worked closely with the Committee and Holmes & Associates to ensure that the questions were worded appropriately for a telephone survey and to improve the flow of the questionnaire. The telephone surveys began on January 16, 2004 and were completed

by March 1, 2004 for Essex, Hamilton, Warren, and Washington counties, and for the northern, more rural portion of Saratoga County. The Siena Research Institute completed an additional survey for the ARHN in May 2007 to include 300 households for Fulton County, as well as for the southern portion of Saratoga County.

The final database composed of 2,060 completed questionnaires yields a confidence interval of plus-or-minus three percentage points around any response rate for the entire sample. When examining data for an individual county, the average sample size of 300 respondents yields a confidence interval of plus-or-minus six percentage points. The survey data tables can be viewed online at: http://www.arhn.org/regional-health-assessment.php. The survey data also can be queried online at: http://www.arhn.org/online-query-tools.php.

Survey Data findings are presented throughout this study where the data has relevance to specific health issues.

NYSDOH Community Health Indicator Data

The ARHN has maintained a regional CHA database since preparing the ARHN multi-county CHA report in 2004. The data for close to 200 health indicators are updated on an annual basis so that trend data is available and can be analyzed for the CHA and CSP process. The vast majority of the indicators provide the incidence rates for specific diseases or injuries, usually represented in the form of hospitalization rates or mortality rates. There are no BRFSS data included in the CHA database outlined here. The BRFSS data are compiled separately, as noted elsewhere in the Methodology section.

The primary source for the CHA data are four county-level datasets available online at the NYSDOH CHA Clearinghouse (http://www.health.state.ny.us/statistics/chac/index.htm), outlined as follows:

- **NYS County Health Assessment Indicators (CHAI)**
  http://www.health.state.ny.us/statistics/chac/chai/index.htm

- **New York State Community Health Data Set**
  http://www.health.state.ny.us/statistics/chac/chds.htm

- **County Health Indicator Profiles**
  http://www.health.state.ny.us/statistics/chip/index.htm

- **NYS Prevention Agenda 20013 Objectives**
  http://www.health.state.ny.us/prevention/prevention_agenda/index.htm

The NYSDOH updates most of these datasets on an annual basis, with 2006 being the latest data year available at the time of this reporting in July 2009.

Holmes & Associates has organized and updated the ARHN CHA indicator database for ARHN and the six county health departments since 2004. The database was originally composed of the CHA Core Indicators recommended for inclusion in the 2005 CHA report (http://www.health.state.ny.us/statistics/chac/cha05_1.htm). The ARHN CHA data compiled for the 2005 report is available on the ARHN.org website in an online query format (http://www.arhn.org/online-query-tools.php).

In 2007 and 2008, the ongoing ARHN CHA work incorporated the health indicator data available in the four datasets outlined above so that data made available by NYSDOH could be used for determining regional ARHN health priorities.

As with the survey data, the CHA indicator data is categorized to provide an organizational scheme. The categorization was adjusted in 2009 to reflect the Prevention Agenda Public Health Priority Areas identified by NYSDOH in 2008. There are now 196 CHA indicators in the ARHN database, organized in 10 categories, as outlined in the table below.

In addition to the data for each indicator for each of the six counties for 2004, 2005, and 2006, the database includes comparative data for Upstate New York, New York State, and the United States. The NYS 2013 and the Healthy People 2010 goals are included where available. The ARHN area average and the county population-based weighted average also are included. Notation identifies those indicators that are part of the NYSDOH Prevention Agenda or that are among the 2005 CHA Core Indicators.

ARHN CHA Data tables are presented throughout this study when there are indicators with relevance to specific health issues.

Public Health Priority Areas	ARHN CHA Indicators
Access to Quality Health Care	6
Tobacco Use	7
Healthy Mothers, Babies, Children	70
Physical Activity / Nutrition	3
Unintentional Injury	12
Healthy Environment	18
Chronic Disease	41
Infectious Disease	29
Community Preparedness	1
Mental Health / Substance Abuse	9
Total:	196

Hospitalization Data

In an effort to provide a complete picture of the health status of the community, two types of hospitalization data are included in this report. Both are derived from the Statewide Planning and Research Cooperative System (SPARCS), which is a comprehensive data reporting system established in 1979 as a result of cooperation between the health care industry and government. Initially created to collect information on discharges from hospitals, SPARCS currently collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State.

In April 1993, an ad hoc task force released a new Universal Data Set (UDS) Specification, which includes reporting codes for use with the UB-92 paper form and a new electronic format. The resulting system streamlines multiple data submission formats into a single format, removing redundant reporting requirements for hospitals and other health care facilities. The valid codes, electronic format, and acceptable data submission media are explained fully in the SPARCS Data Dictionary available at http://www.health.state.ny.us/statistics/sparcs/. The current SPARCS format, which represents a subset of the fields within the complete UDS specification, has been required for submitting records to SPARCS since 1994 discharges.

SPARCS continues to be a major management tool assisting hospitals, agencies, and health care organizations with decision making regarding financial planning and monitoring of inpatient and ambulatory surgery services and costs. In an effort to reflect what is needed by the users of this data, modifications of the required data elements and their formats occur periodically and are reflected in the data presented.

In their effort to support state wide and local planning, the NYSDOH created a searchable database that includes summary data for the years 2001-2007 based on the following conditions which are included in this report:

- AIDS/HIV Related
- Cardiovascular and Other Diseases of the Circulatory System
- Chronic Obstructive Pulmonary Disease
- Diabetes Related
- Injury Prevention
- Neoplasms

The counts and population rates derived from these queries are based on the principal diagnosis codes, the fourteen other diagnosis codes and current, new, and prior New York and Federal DRG's in the SPARCS discharge abstract. These data are not a strict indicator of the number of individuals (cases) with the condition. Rather, they indicate the rate of hospitalizations with related diagnoses. They should be interpreted solely as being the number, or rate,

of hospital stays where the ICD9 code for principal diagnosis, other diagnosis code or DRG is available at http://www.health.state.ny.us/statistics/sparcs. This site will allow you to access public SPARCS data, and provides information on how to create an access account to the secured website. The data in this report was obtained from the NYSDOH secured website.

Prevention Quality Indicators

The Prevention Quality Indicators (PQIs) are a set of measures developed by the federal Agency for Healthcare Research and Quality (AHRQ) for use in assessing the quality of outpatient care for "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The PQIs are measured as rates of admission to the hospital for these conditions in a given population.

The New York State Department of Health in their effort to support state wide and local planning developed a data set of hospitalization data to provide information on the following conditions:

- Short-term complication of diabetes
- Long-term complication of diabetes
- Uncontrolled diabetes
- Lower-extremity amputation among patients with diabetes
- Hypertension
- Congestive heart failure

- Angina
- Chronic obstructive pulmonary disease
- Asthma
- Dehydration
- Bacterial pneumonia
- Urinary tract infection

The PQIs can be used as a starting point for evaluating the overall quality of primary and preventive care in an area and are included in this report for that purpose. They are sometimes characterized as "avoidable hospitalizations," but this does not mean that the hospitalizations were unnecessary or inappropriate at the time they occurred.

The PQI data included in this report is calculated using 2005 and 2006 acute-care hospital discharge data from the Statewide Planning and Research Cooperative System (SPARCS). Discharges from both years were processed with software from the federal Agency for Healthcare Research and Quality (AHRQ), which identifies hospital admissions for each Prevention Quality Indicator (PQI) based on Diagnostic Related Group and other criteria. The hospital admission rates derived on this site are based on an average of those two years of patient records. The number of PQI hospital admissions is converted into a rate using 2006 estimates of the population developed for New York State ZIP codes by Claritas, a leading national demographic firm. All population figures included in the analysis come from Claritas estimates for 2006. "Poor adults" refers to adults living below the federal poverty level, as estimated in the 2000 census. The patient counts by ZIP code reflect total hospital inpatient discharges (for adults as well as children) for 2005-2006. Rates are calculated for each county and the region as a whole based on the state's assignment of zip codes to counties. The growth rate charts were provided by Saratoga Hospital.

PQI data can be found on the following websites: https://www.qualityindicators.ahrq.gov and https://apps.nyhealth.gov/statistics/prevention/quality_indicators/start.map;jsessionid= 3D3FBB04943945F275C59FEFAF912C82

Stakeholder Focus Groups and Input

An important objective of the Community Health Assessment and Community Service Plan process is to obtain in-depth feedback related to what community leaders and consumers feel are the biggest challenges and assets in the community. To obtain this qualitative feedback from professionals and consumers in the region, the ARHN facilitated a series of focus groups with various community leaders, consumers, organizations and stakeholder constituencies.

The purpose of the extensive data gathering was to gain a broad and diverse picture of the health and healthcare issues of the region. The information gathered at each focus group was integrated into this study and complements the quantitative data that has been collected.

To accomplish this task, a team of 18 professionals representing the six counties of the ARHN area were trained by Strategy Solutions, Inc. in the facilitation of stakeholder sessions/focus groups. The November 2008 training equipped the facilitators with the skill to:

- Establish a standard system and agenda for facilitating focus groups
- Understand the process of engaging participants
- Facilitate the stakeholder session and clarify the input received
- Preside over the group dynamics and record the ideas generated
- Use the materials in the focus group tool kit

The training applied the principles of the affinity diagram. Affinity diagramming is a simple but powerful technique for grouping and analyzing large numbers of ideas. The tool is commonly used in workshop-type environments to help participants to work together in identifying, grouping and discussing issues.

The ARHN staff, the Committee and trained facilitators identified contact persons to recruit participants for each group. The focus groups were conducted from November 2008 through April 2009. There were 24 groups conducted throughout the six-county region with a total of 286 participants. The groups included:

- Aging, Long Term Care & Disability Groups
- Consumer Groups
- Correctional Facility Residents and Staff
- Employers
- Government
- Providers of Health & Human Service
- School Staff and Students
- Youth Groups

The following summary details the dates, locations and number of attendees for each focus group.

Focus Group Summary

Date	Event	Location	# Attendees	# Ideas
11/20/08	Facilitator Training	Great Escape Lodge	18	144
1/6/09	Warren County Public Health	Warren County Municipal Building	15	77
1/30/09	Washington County Correctional Facility – B-Pod	Washington County Correctional Facility	6	62
2/6/09	Washington County Correctional Facility C-Pod	Washington County Correctional Facility	4	32
2/9/09	Hamilton County Community Services	Indian Lake	14	57
2/10/09	Glens Falls Hospital	Warren County	9	50
2/18/09	Chestertown Municipal Center	Chestertown	6	36
2/20/09	Washington County Correctional Facility	Washington County Correctional Facility	5	31
2/23/09	Hamilton County Board of Supervisors	Lake Pleasant Courthouse	9	32
2/27/09	Catholic Charities	Glens Falls	5	49
3/3/09	Whitehall Central School Faculty	Whitehall Central School	23	100
3/5/09	Saratoga Springs High School Students	Saratoga Springs	17	78
3/9/09	Washington County Office for Aging Advisory Council	Washington County	9	21
3/13/09	Queensbury HS Health Students	Queensbury High School	32	47
3/19/09	C.R. Bard	Queensbury	5	25
3/23/09	WSWHE BOCES New Visions	Glens Falls	14	78
3/24/09	Indian Lake CS	Hamilton County	13	32
3/27/09	HealthLink – Fulton Co. Healthcare Providers	HealthLink	14	69
3/30/09	Essex County Public Health	Essex County	8	57
3/31/09	Fulton County Chamber of Commerce	Fulton County Chamber Office	11	74
3/31/09	Lake George Senior Center	Lake George	4	25
4/6/09	Johnstown Senior Citizen's Center, Fulton County	Johnstown	30	48
4/9/09	Glens Falls Hospital – Medical Staff	Glens Falls Hospital	3	19
4/27/09	Mountain Lakes EMS	Mountain Lakes EMS, Queensbury	12	80
	Totals		**286**	**1323**

The complete focus group report is located in the Barriers/Priorities Identified at Focus Group section of this study.

Demographics and Socio-Economic Indicators

Population

Table 1: In 2009 there are an estimated 445,985 people living in the six counties of the ARHN area, with almost one-half of that population (49%) living in Saratoga County. In the 1960s and 1970s, the area's population growth exceeded that of the average for the U.S., in large part due to the population growth in Saratoga and Warren counties. In the 1990s, population growth within the ARHN area fell below the average for the U.S. for the first time in 40 years. From 2000 to 2009 the population growth in the ARHN area was 5.1% as compared to 9.1% for the U.S. as a whole. The area's population growth is projected to remain below the U.S. average.
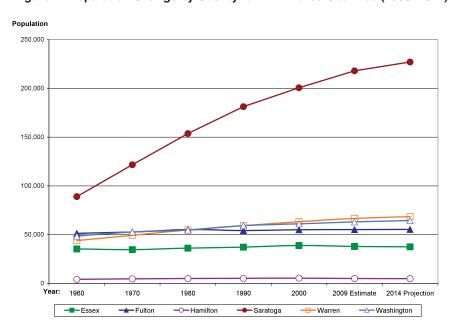
Figure 1: Illustrates the population change by county from 1960-2014.

Table 1. Population and Population Change by County and for the ARHN Area (1960–2014)

Population	Essex	Fulton	Hamilton	Saratoga	Warren	Washington	ARHN Area
1960	35,300	51,304	4,267	89,096	44,002	48,476	272,445
1970	34,631	52,637	4,714	121,679	49,402	52,725	315,788
1980	36,176	55,153	5,034	153,759	54,854	54,795	359,771
1990	37,152	54,191	5,279	181,276	59,209	59,330	396,437
2000	38,851	55,073	5,379	200,635	63,303	61,042	424,283
2009 Estimate	37,925	55,174	5,024	218,066	66,667	63,129	445,985
2014 Projection	37,465	55,390	4,852	227,184	68,580	64,427	457,898

Change	Essex	Fulton	Hamilton	Saratoga	Warren	Washington	ARHN Area	U.S. Avg
1960 - 1970	-1.9%	2.6%	10.5%	36.6%	12.3%	8.8%	15.9%	13.3%
1970 - 1980	4.5%	4.8%	6.8%	26.4%	11.0%	3.9%	13.9%	11.5%
1980 - 1990	2.7%	-1.7%	4.9%	17.9%	7.9%	8.3%	10.2%	9.8%
1990 - 2000	4.6%	1.6%	1.9%	10.7%	6.9%	2.9%	7.0%	13.2%
2000 - 2009	-2.4%	0.2%	-6.6%	8.7%	5.3%	3.4%	5.1%	9.1%
2009 - 2014	-1.2%	0.4%	-3.4%	4.2%	2.9%	2.1%	2.7%	5.9%

Figure 1. Population Change by County for ARHN-area Counties (1960–2014)

Age and Gender
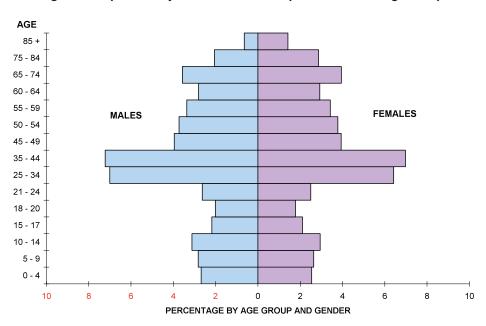
Table 2: The median or average age in the ARHN six-County area is 41 years of age, which is 4 years older than the overall U.S. median age of 37. Over 27% of the area's population is within the two age categories of 25-34 and 35-44, while over three-quarters of the population (79%) are 18 or older. About 11% are under age 10 and about 15% are age 65 or over.

Figure 2: The population pyramid illustrates that the ARHN area has an aging population. There is a smaller population base in the younger age groups, those under age 25, and that is amplified by a steady decline in the two age groups that fall under the age of 10.

Table 2. Population by Age Group and Gender, 6-County ARHN Area (2009)

Age Group	ARHN 6-County Area - 2009					
	Population	%	Male	%	Female	%
Total	445,985		222,088		223,897	
Age 0 - 4	23,305	5.2%	11,947	5.4%	11,358	5.1%
Age 5 - 9	24,365	5.5%	12,595	5.7%	11,770	5.3%
Age 10 - 14	27,022	6.1%	13,905	6.3%	13,117	5.9%
Age 15 - 17	19,116	4.3%	9,714	4.4%	9,402	4.2%
Age 18 - 20	16,904	3.8%	8,992	4.0%	7,912	3.5%
Age 21 - 24	22,880	5.1%	11,724	5.3%	11,156	5.0%
Age 25 - 34	59,860	13.4%	31,239	14.1%	28,621	12.8%
Age 35 - 44	63,319	14.2%	32,216	14.5%	31,103	13.9%
Age 45 - 49	35,191	7.9%	17,642	7.9%	17,549	7.8%
Age 50 - 54	33,489	7.5%	16,638	7.5%	16,851	7.5%
Age 55 - 59	30,280	6.8%	15,000	6.8%	15,280	6.8%
Age 60 - 64	25,551	5.7%	12,504	5.6%	13,047	5.8%
Age 65 - 74	33,563	7.5%	15,947	7.2%	17,616	7.9%
Age 75 - 84	21,947	4.9%	9,163	4.1%	12,784	5.7%
Age 85 +	9,193	2.1%	2,862	1.3%	6,331	2.8%
Age 18 and over	352,177	79.0%	173,927	78.3%	178,250	79.6%
Age 21 and over	335,273	75.2%	164,935	74.3%	170,338	76.1%
Age 65 and over	64,703	14.5%	27,972	12.6%	36,731	16.4%
Median Age	41.4		40.1		42.9	

Figure 2. Population Pyramid: Percent of Population in each Age Group

Households and Household Income

Table 3: In 2009 there were an estimated 179,596 households in the ARHN six-county area. From 2000 to 2009 the total number of households grew by 8.4%. The most common household income category was the $50,000 to $74,999 category. The average household income was near the middle of that range, at $60,425, while the median income was 20% less, at $48,037. For the U.S. as a whole, the average household income was $69,376. The per capita personal income in the ARHN area was $31,863 on average, which was less than the averages for both New York ($46,364) and the U.S. ($38,615).

Over two-thirds (68%) of the households were family households, while the remainder are classified as non-family households, those with either a person living alone or a householder who is not related to any of the other persons sharing their home. There were 14,483 in group quarters and they are accounted for separately from the household data.

On average, there were 2.48 persons per household in the ARHN area in 2009, which is slightly less than the national average of 2.67 persons per household.

Table 3. Households and Household Income by County and Income Group (2009)

Census Item	Essex	Fulton	Hamilton	Saratoga	Warren	Washington	ARHN Total
Households							
2014 Projection	15,148	22,880	2,256	91,870	29,078	25,193	186,425
2009 Estimate	15,161	22,553	2,302	87,332	27,959	24,289	179,596
2000 Census	15,028	21,884	2,362	78,165	25,726	22,458	165,623
1990 Census	13,721	20,995	2,153	66,425	22,559	20,256	146,109
Growth 2009 - 2014	-0.09%	1.45%	-2.00%	5.20%	4.00%	3.72%	3.80%
Growth 2000 - 2009	0.89%	3.06%	-2.54%	11.73%	8.68%	8.15%	8.44%
Growth 1990 - 2000	9.53%	4.23%	9.71%	17.67%	14.04%	10.87%	13.36%
Households by Household Income (2009 Estimate)							
Income Less than $15,000	1,997	3,059	303	5,976	2,941	2,654	16,930
Income $15,000 - $24,999	1,915	3,228	307	7,176	3,408	2,848	18,882
Income $25,000 - $34,999	1,842	3,031	346	7,941	3,594	2,861	19,615
Income $35,000 - $49,999	2,679	4,036	429	12,371	4,794	4,353	28,662
Income $50,000 - $74,999	3,258	4,709	441	19,267	6,030	5,513	39,218
Income $75,000 - $99,999	1,657	2,141	220	13,242	3,214	2,937	23,411
Income $100,000 - $149,999	1,271	1,720	157	13,798	2,669	2,245	21,860
Income $150,000 - $249,999	375	519	66	5,903	915	627	8,405
Income $250,000 - $499,999	125	89	26	1,232	297	198	1,967
Income $500,000 or more	42	21	7	426	97	53	646
Average Household Income (2009 Estimate):	$56,560	$52,220	$55,819	$77,555	$61,371	$59,027	$60,425
Median Household Income (2009 Estimate):	$45,226	$42,279	$41,820	$63,238	$47,629	$48,029	$48,037
Per Capita Personal Income (2007):	$29,145	$30,033	$30,834	$40,714	$33,126	$27,325	$31,863
Households by Household Type (2009 Estimate)							
Family Households	9,919	14,964	1,518	60,040	18,549	17,086	122,076
Non-family Households	5,242	7,589	784	27,292	9,410	7,203	57,520
Group Quarters Population (2009 Estimate):	2,884	1,757	98	4,530	1,409	3,805	14,483

Ethnicity and Race

Table 4: The ARHN area's current estimated Hispanic or Latino population is 2.1%, while the United States current estimated Hispanic or Latino population is 15.5%.

For the ARHN area 94.8% are White alone, 1.9% are Black or African American alone, 0.2% are American Indian or Alaska Native alone, 1.2% are Asian alone, 0.0% are Native Hawaiian and Other Pacific Islander alone, 0.6% are Some Other Race, and 1.2% are Two or More Races.

By comparison, for the entire United States 72.5% are White alone, 12.5% are Black or African American alone, 0.9% are American Indian or Alaska Native alone, 4.4% are Asian alone, 0.2% are Native Hawaiian and Other Pacific Islander alone, 6.7% are Some Other Race, and 2.9% are Two or More Races.

Table 5: Shows the ethnicity and race population estimates for the six-county ARHN area.

Table 4. Ethnicity and Race Percentage of Population by Age Group, for the 6-County ARHN Area (2009)

Percentage of Population by Age	ARHN 6-County Area - Percentage of Estimated Population (2009)							
	Hispanic or Latino	White Alone	Black or African American Alone	American Indian or Alaska Native Alone	Asian Alone	Native Hawaiian and other Pacific Isl. Alone	Some Other Race Alone	Two or More Races
Total	2.1%	94.8%	1.9%	0.2%	1.2%	0.0%	0.6%	1.2%
Age 0 - 4	3.6%	92.6%	1.7%	0.3%	1.5%	0.1%	1.0%	2.9%
Age 5 - 9	3.2%	92.8%	1.6%	0.3%	1.7%	0.0%	0.8%	2.7%
Age 10 - 14	2.9%	93.6%	1.5%	0.4%	1.6%	0.1%	0.8%	2.0%
Age 15 - 17	3.1%	92.9%	2.3%	0.3%	1.8%	0.0%	0.7%	1.9%
Age 18 - 20	3.9%	90.5%	3.7%	0.4%	2.1%	0.0%	1.4%	1.9%
Age 21 - 24	3.7%	91.0%	4.2%	0.3%	1.5%	0.0%	1.2%	1.6%
Age 25 - 34	3.4%	92.4%	3.5%	0.2%	1.5%	0.0%	1.2%	1.1%
Age 35 - 44	2.3%	94.1%	2.7%	0.2%	1.2%	0.0%	0.8%	1.0%
Age 45 - 49	1.4%	96.2%	1.5%	0.2%	1.0%	0.0%	0.4%	0.8%
Age 50 - 54	1.0%	96.7%	1.1%	0.2%	1.0%	0.0%	0.3%	0.6%
Age 55 - 59	0.8%	97.5%	0.8%	0.1%	0.8%	0.0%	0.1%	0.5%
Age 60 - 64	0.7%	97.4%	0.8%	0.1%	1.0%	0.0%	0.2%	0.5%
Age 65 - 74	0.5%	98.4%	0.5%	0.1%	0.5%	0.0%	0.1%	0.4%
Age 75 - 84	0.3%	98.8%	0.5%	0.1%	0.3%	0.0%	0.0%	0.3%
Age 85 and over	0.8%	97.9%	0.7%	0.1%	0.3%	0.0%	0.2%	0.9%
Age 18 and over	1.8%	95.2%	2.0%	0.2%	1.1%	0.0%	0.6%	0.9%
Age 21 and over	1.7%	95.5%	1.9%	0.2%	1.0%	0.0%	0.6%	0.8%
Age 65 and over	0.4%	98.5%	0.5%	0.1%	0.4%	0.0%	0.1%	0.5%

Table 5. Ethnicity and Race Population by Age Group for the 6-County ARHN Area (2009)

Population by Age	ARHN 6-County Area - 2009 Population Estimate							
	Hispanic or Latino	White Alone	Black or African American Alone	American Indian or Alaska Native Alone	Asian Alone	Native Hawaiian and other Pacific Isl. Alone	Some Other Race Alone	Two or More Races
Total	9,490	422,644	8,692	1,013	5,359	140	2,867	5,270
Age 0 - 4	838	21,581	386	77	338	15	224	684
Age 5 - 9	777	22,612	402	85	404	9	204	649
Age 10 - 14	791	25,281	408	109	440	23	209	552
Age 15 - 17	592	17,751	436	65	352	4	140	368
Age 18 - 20	651	15,294	623	69	359	4	237	318
Age 21 - 24	856	20,830	970	77	346	7	284	366
Age 25 - 34	2,032	55,307	2,075	149	904	25	725	675
Age 35 - 44	1,449	59,583	1,696	148	773	22	489	608
Age 45 - 49	488	33,866	522	64	335	5	130	269
Age 50 - 54	319	32,400	385	66	348	7	95	188
Age 55 - 59	228	29,538	251	38	246	7	40	160
Age 60 - 64	180	24,885	193	28	252	7	49	137
Age 65 - 74	157	33,035	164	20	176	4	20	144
Age 75 - 84	62	21,681	117	12	59	0	5	73
Age 85 and over	70	9,000	64	6	27	1	16	79
Age 18 and over	6,492	335,419	7,060	677	3,825	89	2,090	3,017
Age 21 and over	5,841	320,125	6,437	608	3,466	85	1,853	2,699
Age 65 and over	289	63,716	345	38	262	5	41	296

Socio-Economic Status Indicators

Table 6: The New York State Department of Health summarizes selected socio-economic status indicators. For the unemployment and poverty indicators, the majority of ARHN counties exceed the Upstate average.

Table 6 & 7: Looking more closely at the unemployment data for the ARHN area, there was an annual increase of 1-2% from 2007 to 2008 for each of the counties, as there was nationally. New York State had a slightly lower increase in unemployment of .9% for the same period. The increase in unemployment from January 2008 to January 2009 indicates how much more severe the increase in unemployment will be for 2009 as a whole. Unemployment for the ARHN region on average increased 2.9%. The U.S. unemployment rate increased by 3.1%, while the increase in unemployment at the State level was somewhat less at 2.3%. For June, the increase in unemployment in the ARHN area was similar to January, registering 2.8% from June 2008 to June 2009. In general, the June 2009 unemployment rates in the ARHN counties were lower than those at the State or national levels. One exception was Fulton County where the unemployment rate was 1% higher than the State rate. The somewhat lower June unemployment rates in the ARHN area reflect, in part, the importance of the area's seasonal construction, hospitality, and service industries.

Table 6. Socio-Economic Status Indicators

Socio-Economic CHA Indicators	Essex	Fulton	Hamilton[1]	Saratoga	Warren	Washington	ARHN Avg	ARHN Wght'd Avg[2]	Up-state Avg	NYS Avg
% unemployed (2004-06)	5.5	5.5	5.3	3.7	4.7	4.5	4.9	4.4	4.6	5.1
% of population at or below poverty level (2005)	11.9	13.2	10.5	6.4	9.7	11.4	10.5	9.0	10.1	13.9
% of children <18 at or below poverty level (2005)	17.1	19.8	14.9	8.0	14.8	15.7	15.1	12.4	13.5	19.7
% Annual high school drop outs (2005-06)	2.6	2.4	0.6	2.0	1.4	1.4	1.7	1.9	2.5	3.7

1 Low population and a small number of events means that the rates for Hamilton County can be unstable.
2 The weighted average for all ARHN counties factors in the population differences between the counties.
☐ County or ARHN average is "worse" than the Upstate average.
     Source: NYS DOH County Health Assessment Indicators - http://www.health.state.ny.us/statistics/chac/chai/index.htm

Table 7. Unemployment Rates for the ARHN Area by County

Unemployment Rates (percentage unemployed)*									
	January Comparison			June Comparison			Annual Comparison		
Area	Jan, 07	Jan, 08	Jan, 09	Jun, 07	Jun, 08	Jun, 09	2006	2007	2008
U.S.	5.0	5.4	8.5	4.7	5.7	9.7	4.6	4.6	5.8
NY	5.0	5.3	7.6	4.5	5.1	8.6	4.6	4.5	5.4
Essex	7.4	7.8	11.0	5.1	5.7	8.7	5.7	5.7	6.8
Fulton	6.1	7.0	10.6	5.2	5.7	9.6	5.4	5.5	6.9
Hamilton	6.8	8.6	11.5	3.0	4.1	6.1	5.1	4.8	6.4
Saratoga	4.2	4.8	6.7	3.5	4.4	6.7	3.6	3.7	4.6
Warren	6.0	6.5	10.0	3.7	4.6	7.1	4.7	4.6	5.8
Washington	5.3	6.1	8.4	3.9	4.7	7.8	4.3	4.3	5.5
ARHN AVG	6.0	6.8	9.7	4.1	4.9	7.7	4.8	4.8	6.0

* The number of unemployed as a percentage of the labor force, age 16 years and over.
    These unemployment rates are not seasonally adjusted.

Access to Quality Health Care

Dental Care

Figure 3: The majority of ARHN respondents (70%) surveyed in 2008 indicated that they had seen a dentist in the past year, the rate is about the same as it was in the 2004/07 ARHN survey (69%). This is about the same as the state average (71%), and much lower than the Healthy People 2010 goal of 83%. In the 2008 survey, Warren County has the highest percentage (76%) of respondents indicating that they have seen a dentist in the past year, while Hamilton County (67%), Fulton (65%) and Washington (64%) all have rates lower than the state and regional averages.

Figure 4: ARHN respondents who saw a dentist in the past year were likely to have had their teeth cleaned at that time (71%), which is comparable to the state average of 72%. Warren and Saratoga counties had the highest percentage (75%) of respondents who had their teeth cleaned in the past year. Hamilton County (67%), and Washington County (64%), had lower rates than the regional and state averages.

Figure 5: Approximately half (50%) of ARHN respondents indicated that they had a tooth extracted due to decay or gum disease during the past year, which is the same as the state average. Fulton County (56%) was slightly higher than the state and regional averages for having had a tooth extracted due to decay or gum disease. Saratoga had the lowest percentage (45%) of respondents indicating that they have had a tooth extracted due to decay or gum disease.

Figure 6: Fulton County also had the highest percentage of respondents age 65 and older reporting that they have had all permanent teeth extracted (23%) due to decay or gum disease. Hamilton County reports the lowest percentage of respondents age 65 and older who have had all their teeth extracted (9%).

Table 8: In the 2004/07 survey, participants were asked to identify the reasons why they did not receive dental care. Lack of dental insurance coverage was cited by more than half of the respondents (50.8%) of those who did not see a dental care provider at least once a year.
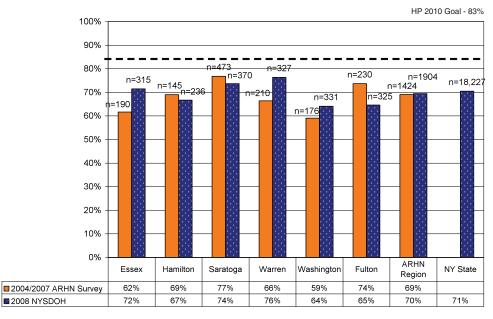
Figure 3. Percentage of Adults Visited Dentist within the Past Year

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	62%	69%	77%	66%	59%	74%	69%	
2008 NYSDOH	72%	67%	74%	76%	64%	65%	70%	71%
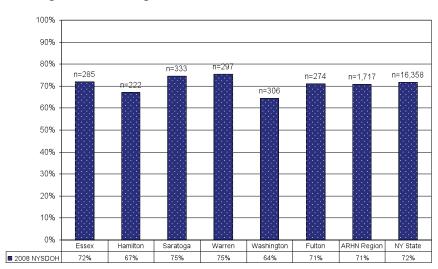
Figure 4. Percentage of Adults Who Had Teeth Cleaned within Past Year

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	72%	67%	75%	75%	64%	71%	71%	72%

Data labels: n=285, n=222, n=333, n=297, n=306, n=274, n=1,717, n=16,358

Figure 5. Percentage of Adults Who Had Permanent Teeth Extracted Due to Decay or Gum Disease

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	51%	50%	45%	50%	50%	56%	50%	50%

Data labels: n=309, n=237, n=365, n=324, n=330, n=325, n=1,890, n=18,039
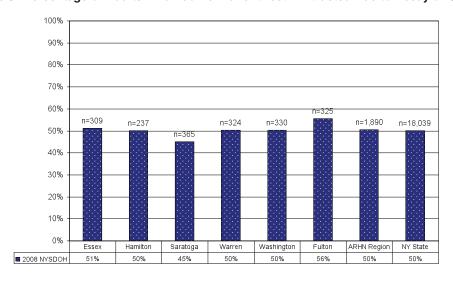
Figure 6. Percentage of Adults age 65 and Older who had ALL Permanent Teeth Extracted

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	16%	9%	17%	12%	20%	23%	16%	18%

Data labels: n=127, n=95, n=126, n=129, n=116, n=118, n=711, n=5,918
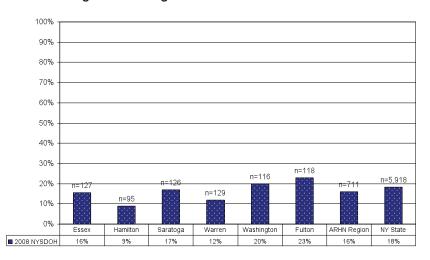
Table 8. Main Reason for Not Getting Dental Care by County

What is the main reason that you are not getting the dental health care you think you need?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
Cannot find a dentist to accept my insurance	Count	8	2	6	4	5	5	30
	%	8.1%	5.3%	5.2%	4.7%	5.7%	8.5%	6.2%
Cost: No Dental Insurance or only partial coverage	Count	45	16	65	39	44	37	246
	%	45.5%	42.1%	56.5%	45.9%	50.0%	62.7%	50.8%
Too far to travel to the dental services I needed	Count	1	4	3	1	0	1	10
	%	1.0%	10.5%	2.6%	1.2%	.0%	1.7%	2.1%
Lack of transportation	Count	0	0	2	0	0	0	2
	%	.0%	.0%	1.7%	.0%	.0%	.0%	.4%
Unable to find a Dentist to accept me as a patient	Count	3	1	1	1	0	2	8
	%	3.0%	2.6%	.9%	1.2%	.0%	3.4%	1.7%
Office wasn't open when I could get there	Count	0	1	1	0	1	0	3
	%	.0%	2.6%	.9%	.0%	1.1%	.0%	.6%
Too long to wait for an appointment	Count	0	0	2	1	4	1	8
	%	.0%	.0%	1.7%	1.2%	4.5%	1.7%	1.7%
No childcare	Count	0	0	1	0	0	0	1
	%	.0%	.0%	.9%	.0%	.0%	.0%	.2%
No teeth	Count	18	3	14	14	10	10	69
	%	18.2%	7.9%	12.2%	16.5%	11.4%	16.9%	14.3%
We never go to dentist	Count	6	3	7	5	9	0	30
	%	6.1%	7.9%	6.1%	5.9%	10.2%	.0%	6.2%
Don't Know/Not Sure	Count	16	7	8	15	9	3	58
	%	16.2%	18.4%	7.0%	17.6%	10.2%	5.1%	12.0%
Refused	Count	2	1	5	5	6	0	19
	%	2.0%	2.6%	4.3%	5.9%	6.8%	.0%	3.9%

Primary Care Provider
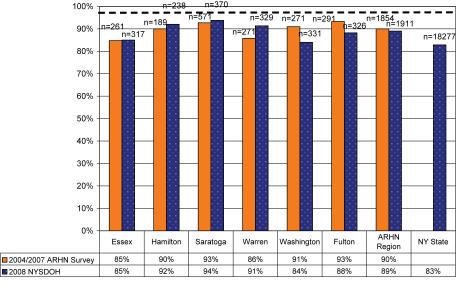
Figure 7: In the 2008 survey, most ARHN respondents (89%) indicated that they have a primary care provider and the rate is about the same (90%) as the 2004/07 survey. This is higher than the state rate of 83%, although it is lower than the Healthy People 2010 goal of 96%. In the 2008 survey, several regional counties came close to the Healthy People 2010 goal, Saratoga (94%) and Hamilton (92%). Washington (84%) and Essex (85%) had the lowest regional county rates, but were still higher than the state rate.

Table 9: Respondents who indicated that they did not have a primary care provider were asked in the 2004/07 survey why they did not have a primary care provider. Approximately one in three respondents (36%) indicated that they did not have a primary care provider because they did not need one.

Figure 7. Percentage of Adults Reporting Having Primary Care Provider*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	85%	90%	93%	86%	91%	93%	90%	
2008 NYSDOH	85%	92%	94%	91%	84%	88%	89%	83%

*Primary Care Provider defined as Regular Health Care Provider or Personal Doctor in 2008 NYSDOH and Family Doctor in 2004/2007 ARHN survey.

Table 9. Reason Respondents Do Not Have Family Doctor by County

Is there a reason why you do not have a family doctor?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
Do not need one	Count	15	6	16	17	12	8	74
	%	31.9%	28.6%	35.6%	37.8%	44.4%	38.1%	35.9%
Do not know one	Count	2	2	4	2	2	4	16
	%	4.3%	9.5%	8.9%	4.4%	7.4%	19.0%	7.8%
Cannot afford one	Count	3	0	4	2	4	0	13
	%	6.4%	.0%	8.9%	4.4%	14.8%	.0%	6.3%
Too far to travel	Count	1	0	1	2	1	0	5
	%	2.1%	.0%	2.2%	4.4%	3.7%	.0%	2.4%
Other	Count	16	13	13	12	8	8	70
	%	34.0%	61.9%	28.9%	26.7%	29.6%	38.1%	34.0%
Don't Know/Not Sure	Count	9	0	7	9	0	1	26
	%	19.1%	.0%	15.6%	20.0%	.0%	4.8%	12.6%
Refused	Count	1	0	0	1	0	0	2
	%	2.1%	.0%	.0%	2.2%	.0%	.0%	1.0%
Total	Count	47	21	45	45	27	21	206
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Primary Care Utilization

Table 10: When asked in the 2004/07 survey where they typically go when they need medical attention, the majority of respondents (80%) indicated that they typically go to a doctors office, while about 9% indicated that they will go to an emergency room. This rate was higher in Fulton County, where 19% indicated that they will go to the emergency room.

Figure 8: In the 2004/07 survey, 11% of regional respondents indicated that they had difficulty in purchasing prescriptions. Fulton County had the lowest rate of 8%, while Washington County had the highest rate of 14%.

Table 11: In the 2004/07 survey, respondents were asked why they have difficulty purchasing prescriptions. The most frequent responses were "insurance only covers part of the cost, or co-pay is too high" (37%) and "no insurance or insurance doesn't cover prescriptions" (34%).

Table 10. Where Respondents Go for Medical Attention by County

When you are sick and need medical attention, where do you usually go?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
Doctor's office, clinic, or community health center	Count	239	179	489	266	247	221	1641
	%	77.6%	85.2%	79.4%	84.2%	82.9%	70.8%	79.7%
Hospital outpatient department	Count	8	8	22	12	10	12	72
	%	2.6%	3.8%	3.6%	3.8%	3.4%	3.8%	3.5%
Hospital emergency room	Count	36	10	41	16	18	58	179
	%	11.7%	4.8%	6.7%	5.1%	6.0%	18.6%	8.7%
Urgent care center	Count	5	5	31	8	8	4	61
	%	1.6%	2.4%	5.0%	2.5%	2.7%	1.3%	3.0%
Some other place	Count	9	3	3	7	3	1	26
	%	2.9%	1.4%	.5%	2.2%	1.0%	.3%	1.3%
No usual place	Count	8	2	15	5	6	4	40
	%	2.6%	1.0%	2.4%	1.6%	2.0%	1.3%	1.9%
Don't Know/Not Sure	Count	2	3	14	2	4	12	37
	%	.6%	1.4%	2.3%	.6%	1.3%	3.8%	1.8%
Refused	Count	1	0	1	0	2	0	4
	%	.3%	.0%	.2%	.0%	.7%	.0%	.2%
Total	Count	308	210	616	316	298	312	2060
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
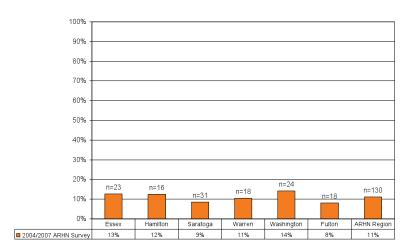
Figure 8. Percentage of Respondents That Have Difficulty Purchasing Prescriptions

2004/2007 ARHN Survey	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	13%	12%	9%	11%	14%	8%	11%

Table 11. Main Reason Respondents Had Difficulty Getting Prescription

What is the main reason you have difficulty getting prescribed medication?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
No insurance or my insurance does not cover prescriptions	Count	7	4	9	7	13	4	44
	%	30.4%	25.0%	29.0%	38.9%	54.2%	22.2%	33.8%
My insurance only covers part of the cost, or co pay is too high	Count	9	4	15	7	7	6	48
	%	39.1%	25.0%	48.4%	38.9%	29.2%	33.3%	36.9%
Lack of transportation to pharmacy	Count	1	2	2	0	1	0	6
	%	4.3%	12.5%	6.5%	.0%	4.2%	.0%	4.6%
Procedures for ordering monthly prescription are too complicated	Count	0	2	2	0	0	1	5
	%	.0%	12.5%	6.5%	.0%	.0%	5.6%	3.8%
Other	Count	5	4	2	3	3	7	24
	%	21.7%	25.0%	6.5%	16.7%	12.5%	38.9%	18.5%
Don't Know/Not Sure	Count	1	0	0	0	0	0	1
	%	4.3%	.0%	.0%	.0%	.0%	.0%	.8%
Refused	Count	0	0	1	1	0	0	2
	%	.0%	.0%	3.2%	5.6%	.0%	.0%	1.5%
Total	Count	23	16	31	18	24	18	130
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Health Insurance

Figure 9: Most regional respondents (89%) who completed the 2008 survey indicated that they currently have health insurance of any kind. This rate is similar to the 90% reporting having health insurance in the 2004/07 survey. The 2008 rate is somewhat higher than the state average (86%) but lower than the Healthy People 2010 goal of 100%. In 2008, Warren (92%) and Saratoga (91%) counties had the highest regional rates of health insurance while Fulton and Essex counties had the lowest rates at 87%.

Figure 10: The majority of adults in the region age 18-64 (86%) indicate that they currently have health insurance. This also compares to the state rate of 84%.

Figure 11: Among adults in the region, 11% indicate that they do not have health insurance, which is slightly lower than the state average of 14%. Warren County has the lowest percentage of adults (8%) indicating that they do not have health insurance while Essex and Fulton counties have the highest percentages at 13%.

Figure 12: Among adults age 18-64, 14% indicated that they do not have health insurance, which is lower than the state average of 16%. Hamilton County had the highest regional rate of adults age 18-64 indicating that they did not have health insurance at 17%, and Warren County had the lowest at 10%.

Table 12: In the 2004/07 survey, respondents were asked about the name or type of health insurance they had. The most frequent responses were Blue Cross/Blue Shield (27%) and Medicare (16%).

Table 13: In the 2004/07 survey, respondents were also asked why they did not have health insurance. The most frequent responses were "couldn't afford the premiums" (21%) and lost or changed jobs (7%).
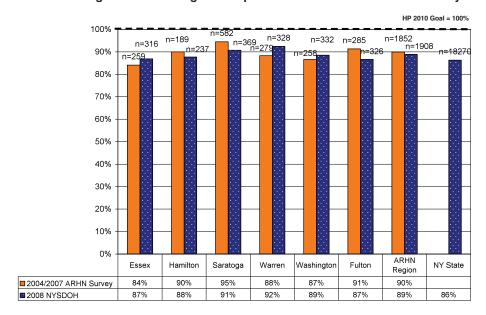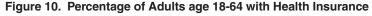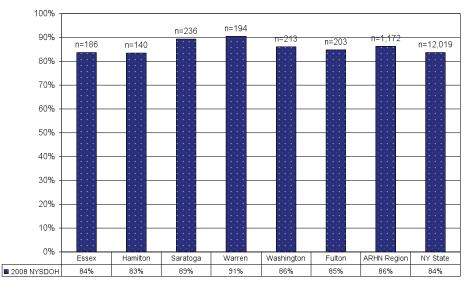
Figure 9. Percentage of Respondents with Health Insurance of any kind

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	84%	90%	95%	88%	87%	91%	90%	
2008 NYSDOH	87%	88%	91%	92%	89%	87%	89%	86%

Figure 10. Percentage of Adults age 18-64 with Health Insurance

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	84%	83%	89%	91%	86%	85%	86%	84%
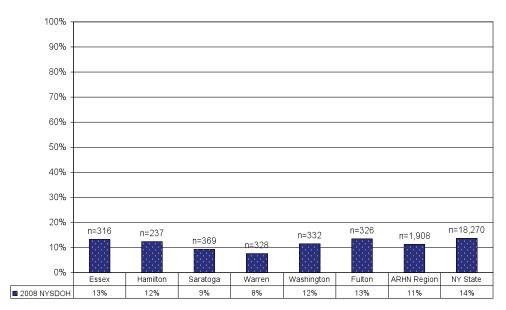
Figure 11. Percentage of Adults with No Health Insurance

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	13%	12%	9%	8%	12%	13%	11%	14%

n=316, n=237, n=369, n=328, n=332, n=326, n=1,908, n=18,270

Figure 12. Percentage of Adults age 18-64 with No Health Insurance

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	16%	17%	11%	10%	14%	15%	14%	16%

n=186, n=140, n=236, n=194, n=213, n=203, n=1,172, n=12,019
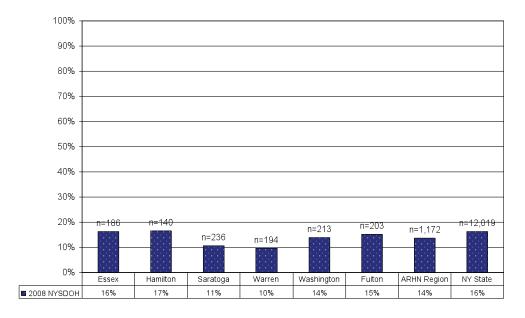
Table 12. Name/Type of Health Insurance by County

What is the name or type of health insurance you have?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
Medicare	Count	40	36	68	42	35	68	289
	%	15.4%	19.0%	11.7%	15.1%	13.6%	23.9%	15.6%
Medicaid	Count	12	2	7	14	17	8	60
	%	4.6%	1.1%	1.2%	5.0%	6.6%	2.8%	3.2%
Child Health Plus	Count	2	0	3	4	1	0	10
	%	.8%	.0%	.5%	1.4%	.4%	.0%	.5%
Family Health Plus	Count	5	2	5	8	10	2	32
	%?	1.9%	1.1%	.9%	2.9%	3.9%	.7%	1.7%
Blue Cross/Blue Shield (BCBS) Utica/Watertown	Count	64	37	62	47	44	42	296
	%	24.7%	19.6%	10.7%	16.8%	17.1%	14.7%	16.0%
BCBS Western NY	Count	5	5	7	4	3	1	25
	%	1.9%	2.6%	1.2%	1.4%	1.2%	.4%	1.3%
Blue Shield Northeastern NY	Count	49	10	39	40	31	13	182
	%	18.9%	5.3%	6.7%	14.3%	12.0%	4.6%	9.8%
Capital District Physicians Health Plan	Count	5	16	120	20	29	23	213
	%	1.9%	8.5%	20.6%	7.2%	11.2%	8.1%	11.5%
Empire	Count	31	21	71	29	29	23	204
	%	12.0%	11.1%	12.2%	10.4%	11.2%	8.1%	11.0%
Fidelis Care	Count	2	5	1	0	2	2	12
	%	.8%	2.6%	.2%	.0%	.8%	.7%	.6%
GHI	Count	4	4	13	6	4	6	37
	%	1.5%	2.1%	2.2%	2.2%	1.6%	2.1%	2.0%
Wellcare	Count	2	6	3	3	2	1	17
	%	.8%	3.2%	.5%	1.1%	.8%	.4%	.9%
Don't Know/Not Sure	Count	33	43	83	48	41	11	259
	%	12.7%	22.8%	14.3%	17.2%	15.9%	3.9%	14.0%
Refused	Count	5	2	19	14	10	4	54
	%	1.9%	1.1%	3.3%	5.0%	3.9%	1.4%	2.9%
Other	Count	0	0	81	0	0	81	162
	%	.0%	.0%	13.9%	.0%	.0%	28.4%	8.7%
Total	Count	259	189	582	279	258	285	1852
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Blue Cross/Blue Shield (BCBS) Utica/Watertown, BCBS Western NY, and Blue Shield Northeastern NY were combined
in the narrative to create one number for Blue Cross/Blue Shield utilization = 27%

Table 13. Main Reason Respondents are Without Health Care Coverage by County

What is the main reason you are without health care coverage?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
Couldn't afford to pay the premiums	Count	31	14	19	19	28	9	120
	%	25.8%	20.3%	17.9%	16.1%	21.4%	33.3%	21.0%
Employer doesn't offer or stopped offering coverage	Count	4	6	7	4	2	4	27
	%	3.3%	8.7%	6.6%	3.4%	1.5%	14.8%	4.7%
Insurance company refused coverage	Count	2	0	1	1	0	2	6
	%	1.7%	.0%	.9%	.8%	.0%	7.4%	1.1%
Lost job or changed employers [includes any person who had been provided insurance prior to job loss or change]	Count	8	3	5	9	11	5	41
	%	6.7%	4.3%	4.7%	7.6%	8.4%	18.5%	7.2%
Lost Medicaid or Medical Assistance eligibility	Count	1	0	1	0	1	0	3
	%	.8%	.0%	.9%	.0%	.8%	.0%	.5%
Change in family situation [divorce, separation, death, etc.]	Count	1	0	0	0	1	0	2
	%	.8%	.0%	.0%	.0%	.8%	.0%	.4%
Cut back to part time or became temporary employee	Count	3	0	1	0	3	0	7
	%	2.5%	.0%	.9%	.0%	2.3%	.0%	1.2%
Benefits from employer or former employer ran out	Count	0	0	0	1	2	0	3
	%	.0%	.0%	.0%	.8%	1.5%	.0%	.5%
Became ineligible because of age or because left school	Count	2	1	2	0	0	2	7
	%	1.7%	1.4%	1.9%	.0%	.0%	7.4%	1.2%
Don't Know/Not Sure	Count	4	0	5	11	8	0	28
	%	3.3%	.0%	4.7%	9.3%	6.1%	.0%	4.9%
Other	Count	44	31	46	42	44	5	212
	%	36.7%	44.9%	43.4%	35.6%	33.6%	18.5%	37.1%
Refused	Count	20	14	19	31	31	0	115
	%	16.7%	20.3%	17.9%	26.3%	23.7%	.0%	20.1%
Total	Count	120	69	106	118	131	27	571
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Health Status

Figure 13: In the 2008 survey, only a small portion (14%) of regional respondents rated their health as fair or poor. This compares favorably to the state average of 16% and is lower than the 2004/07 survey (21%). It should be noted that some variation in the data from the previous survey may be due to low sample sizes in some counties. Fulton County has a slightly higher percentage of respondents indicating that their health is fair or poor (20%), while Hamilton County's rate is somewhat lower (11%).

Figure 14: In the 2008 survey, ten percent (10%) of regional adults reported having poor physical health for 14 or more days within the past month, which is comparable to the state rate of 11%. Hamilton has the lowest county rate at 6%, while Fulton County has the highest county rate in the region at 12%.
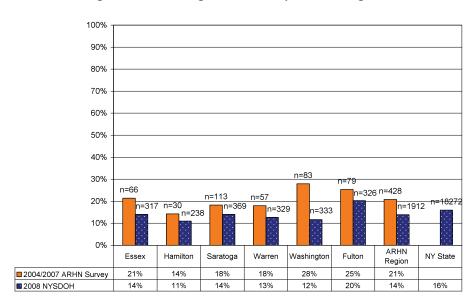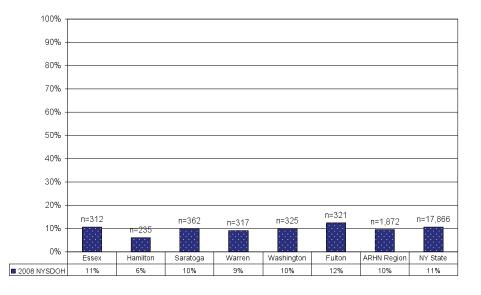
Figure 13. Percentage of Adults Reported Having Fair or Poor Health

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	21%	14%	18%	18%	28%	25%	21%	
2008 NYSDOH	14%	11%	14%	13%	12%	20%	14%	16%

Figure 14. Percentage of Adults Reporting Poor Physical Health 14 or more Days within Past Month

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	11%	6%	10%	9%	10%	12%	10%	11%

Delayed Care

Figure 15: In the 2008 survey, only a small portion (11%) of the regional respondents indicated that they delayed health care due to cost, which is comparable to the state rate of 13%. All counties report similar rates, although Fulton is the highest (14%) while Hamilton is the lowest (8%).

Table 14: Outlines the reasons respondents did not get or delayed care as reported in the 2004/07 survey. The most frequent response was lack of insurance or because of out of pocket cost (31.4%).
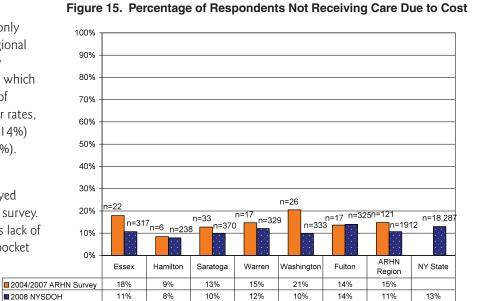
Figure 15. Percentage of Respondents Not Receiving Care Due to Cost

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	18%	9%	13%	15%	21%	14%	15%	
2008 NYSDOH	11%	8%	10%	12%	10%	14%	11%	13%

Table 14: Reason Not Get/Delayed Care by County

What was the main reason you did not get or delayed getting care?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
Lack of insurance or because of out of pocket cost	Count	9	3	5	3	11	7	38
	%	40.9%	50.0%	15.2%	17.6%	42.3%	41.2%	31.4%
Could not get an appointment or too long to wait for appointment	Count	0	0	4	1	2	3	10
	%	.0%	.0%	12.1%	5.9%	7.7%	17.6%	8.3%
Did not know where to go or unable to find a Doctor to accept me as a patient	Count	0	0	0	1	1	0	2
	%	.0%	.0%	.0%	5.9%	3.8%	.0%	1.7%
Too far to travel to the medical services I needed	Count	0	0	1	0	1	1	3
	%	.0%	.0%	3.0%	.0%	3.8%	5.9%	2.5%
Lack of transportation	Count	0	0	1	0	2	0	3
	%	.0%	.0%	3.0%	.0%	7.7%	.0%	2.5%
Afraid, scared, worried or embarrassed	Count	1	0	3	0	2	0	6
	%	4.5%	.0%	9.1%	.0%	7.7%	.0%	5.0%
Don't believe in or trust doctors	Count	0	0	1	0	0	0	1
	%	.0%	.0%	3.0%	.0%	.0%	.0%	.8%
Didn't think it would help	Count	1	0	1	2	0	0	4
	%	4.5%	.0%	3.0%	11.8%	.0%	.0%	3.3%
Didn't think it was serious	Count	2	3	7	3	3	6	24
	%	9.1%	50.0%	21.2%	17.6%	11.5%	35.3%	19.8%
Other	Count	4	0	8	4	2	0	18
	%	18.2%	.0%	24.2%	23.5%	7.7%	.0%	14.9%
Don't Know/Not Sure	Count	3	0	1	2	0	0	6
	%	13.6%	.0%	3.0%	11.8%	.0%	.0%	5.0%
Refused	Count	2	0	1	1	2	0	6
	%	9.1%	.0%	3.0%	5.9%	7.7%	.0%	5.0%
Total	Count	22	6	33	17	26	17	121
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Visited Doctor

Figure 16: The majority of regional respondents (71%) in 2008 indicated that they visited a doctor for a routine checkup in the past year, which is lower than the 80% in 2004/07. This is somewhat lower than the state rate of 75%. Fulton County had the highest regional rate of 80%, while Essex (67%), Warren (65%) and Washington (62%) all fell below the regional average.

Figure 17: In the 2008 survey, a high percentage (84%) of the regional respondents indicated that they had visited a doctor within the past two years. Warren (81%) and Washington (79%) counties fell below the regional rate, while Fulton and Saratoga counties had the highest (89%).

Table 15: Outlines the reasons given by respondents why it has been longer than one year since a routine checkup as reported in the 2004/07 survey.
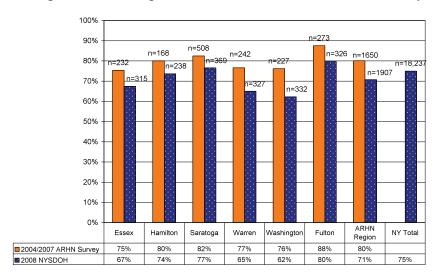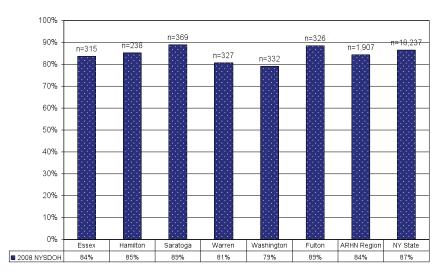
Figure 16. Percentage of Adults Visited Doctor for Routine Check Up, Past Year

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY Total
2004/2007 ARHN Survey	75%	80%	82%	77%	76%	88%	80%	
2008 NYSDOH	67%	74%	77%	65%	62%	80%	71%	75%

Figure 17. Percentage of Adults Visited Doctor for Routine Check Up, Within Past Two Years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	84%	85%	89%	81%	79%	89%	84%	87%

Table 15. Reason it Has Been Longer Than 1 Year Since Routine Checkup

Why has it been more than a year since you had a routine checkup?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
No reason or need to; I am healthy; don't need a Dr.	Count	34	16	38	25	22	13	148
	%	66.7%	66.7%	55.9%	64.1%	59.5%	50.0%	60.4%
Lack of insurance or because of out of pocket cost	Count	3	2	10	6	6	5	32
	%	5.9%	8.3%	14.7%	15.4%	16.2%	19.2%	13.1%
Could not get an appointment or too long to wait for appointment	Count	1	0	3	0	2	0	6
	%	2.0%	.0%	4.4%	.0%	5.4%	.0%	2.4%
Too far to travel	Count	0	0	0	1	0	0	1
	%	.0%	.0%	.0%	2.6%	.0%	.0%	.4%
Lack of transportation	Count	0	1	0	0	0	0	1
	%	.0%	4.2%	.0%	.0%	.0%	.0%	.4%
Afraid, scared, worried or embarrassed	Count	1	1	1	0	1	0	4
	%	2.0%	4.2%	1.5%	.0%	2.7%	.0%	1.6%
Don't believe in or trust doctors	Count	5	0	3	2	0	1	11
	%	9.8%	.0%	4.4%	5.1%	.0%	3.8%	4.5%
Other	Count	6	4	10	3	4	6	33
	%	11.8%	16.7%	14.7%	7.7%	10.8%	23.1%	13.5%
Don't Know/Not Sure	Count	1	0	3	2	2	1	9
	%	2.0%	.0%	4.4%	5.1%	5.4%	3.8%	3.7%
Total	Count	51	24	68	39	37	26	245
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
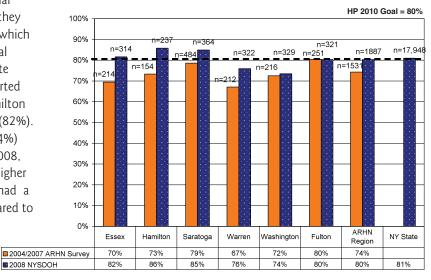
Early Screening

Cholesterol Test

Figure 18: Illustrates that in the 2008 survey, the majority of regional respondents (80%) indicated that they have had a blood cholesterol test, which meets the Healthy People 2010 goal of 80% and compares with the state rate of 81%. Several counties reported rates in excess of the average, Hamilton (86%), Saratoga (85%), and Essex (82%). Warren (76%) and Washington (74%) had the lowest regional rates. In 2008, all counties reported the same or higher percentage of respondents having had a blood cholesterol test when compared to the 2004/07 survey results.

Figure 18. Percentage of Adults Who Ever Had Blood Cholesterol Test

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	70%	73%	79%	67%	72%	80%	74%	
2008 NYSDOH	82%	86%	85%	76%	74%	80%	80%	81%

Figure 19: Illustrates that most regional respondents (76%) reported having a blood cholesterol check within the past five years. Saratoga (83%) and Hamilton (81%) counties had the highest rates, while Warren (71%) and Washington (69%) fell below both the state and regional rates.
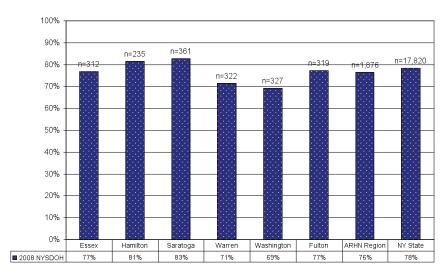
Figure 19. Percentage of Adults Blood Cholesterol Checked within the past 5 Years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	77%	81%	83%	71%	69%	77%	76%	78%

Mammogram

Figure 20: In the 2004/2007 survey, the majority of regional women (66%) indicated that they had ever had a mammogram. Fulton County had the highest rate (76%) while Essex County had the lowest rate (61%).

Figure 21: In the 2008 survey, only women age 40 and older were asked if they had ever had a mammogram. The majority of regional women (93%) indicated that they had ever had a mammogram, which is higher than the state rate of 90%. Hamilton County had the highest rate with 96%, and Washington County had the lowest regional rate at 88%.

Figure 20. Percentage of Respondents Who Had Mammogram

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	61%	72%	66%	63%	63%	76%	66%
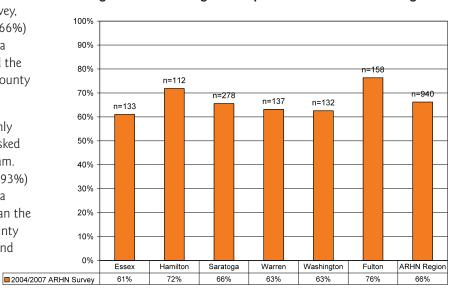
Figure 22: In the 2008 survey, the majority (81%) of respondent women age 40 and older indicated that they had a mammogram within the past two years, compared with the state rate of 78%. Warren had the highest county rate at 86%, while Washington had the lowest rate at 78%.

Figure 23: In the 2008 survey, a slightly higher percentage of regional women age 50 and older (84%) reported that they had a mammogram within the past two years, compared to a state rate of 83%. Fulton County had the lowest county rate at 79% while Saratoga and Warren counties had the highest rate at 86%.
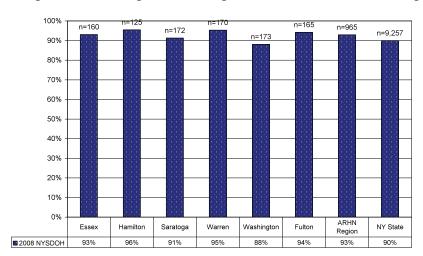
Figure 21. Percentage of Women Age 40 and Older Ever Had Mammogram

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
■2008 NYSDOH	93%	96%	91%	95%	88%	94%	93%	90%

Figure 22. Percentage of Women age 40 and Older who had Mammogram within past 2 years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
■2008 NYSDOH	81%	80%	81%	86%	78%	81%	81%	78%
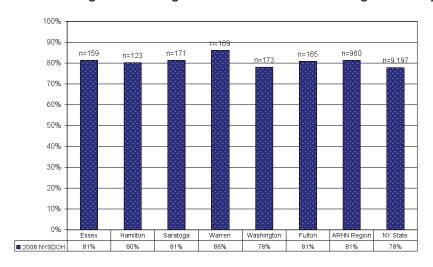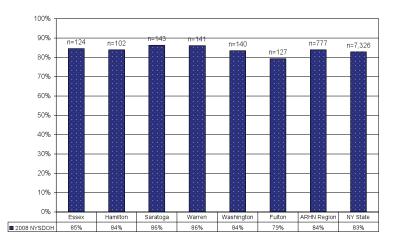
Figure 23. Percentage of Women age 50 and Older who had Mammogram within past 2 years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
■2008 NYSDOH	85%	84%	86%	86%	84%	79%	84%	83%

Pap Test

Figure 24: The majority of women surveyed in 2008 (94%) indicated that they have ever had a pap test. This meets the Healthy People 2010 goal and is favorable to the state rate of 93%. Warren and Washington counties have the highest regional rate (98%), while Hamilton County has the lowest at 91%.

Figure 25: Most regional women (81%) have had a pap test within the past three years. This is somewhat lower than the state rate of 84%. There was little variation among counties, although Fulton reported the lowest rate at 74%.
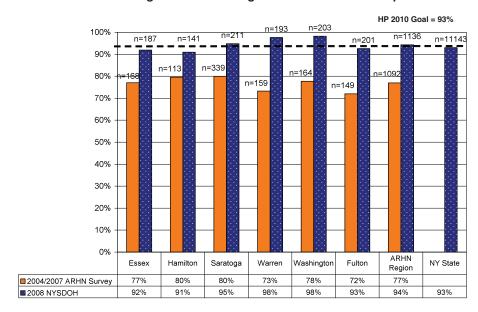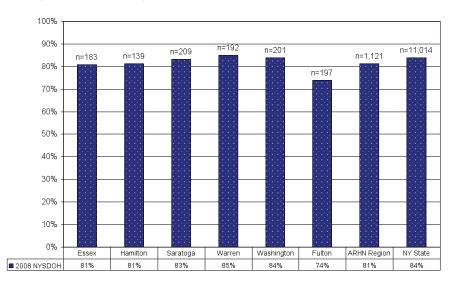
Figure 24. Percentage of Women Ever Had Pap Test

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	77%	80%	80%	73%	78%	72%	77%	
2008 NYSDOH	92%	91%	95%	98%	98%	93%	94%	93%

Figure 25. Percentage of Women Who Had Pap Test Within The Past 3 Years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	81%	81%	83%	85%	84%	74%	81%	84%

PSA Cancer Screening (Prostate Specific Antigen Test)

Figure 26: In the 2004/07 survey, about half of regional men surveyed (48%) indicated that they had ever had a PSA cancer screening test at anytime in their life. Fulton County had the highest rate at 57%, while Hamilton and Washington counties had the lowest at 41%.

Figure 27: In the 2008 survey, only men age 40 and older were asked if they had ever had a PSA cancer screening. The majority of regional men age 40 and older (68%) indicated that they had the screening, compared with the state rate of 69%. Hamilton had the highest county rate at 72%, while Washington was lowest at 61%.

Figure 28: In the 2008 survey, more than half of men age 40 and older (57%) indicated that they had a PSA Screening in the past two years, comparable to the state rate of 59%. Washington County had the lowest percentage at 50%, while Hamilton County had the highest percentage at 64%.
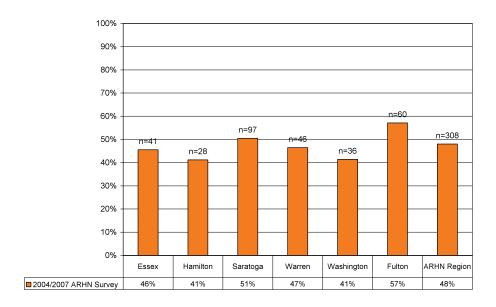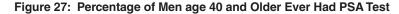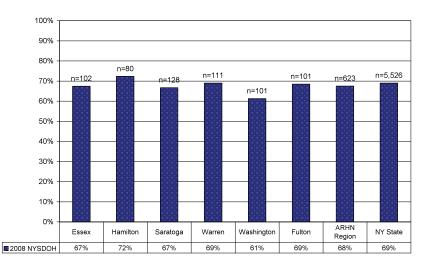
Figure 26: Percentage of Adult Men Who Had PSA Test at Anytime in Their Life

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	46%	41%	51%	47%	41%	57%	48%

Figure 27: Percentage of Men age 40 and Older Ever Had PSA Test

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	67%	72%	67%	69%	61%	69%	68%	69%
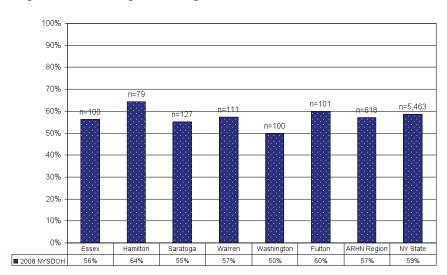
Figure 28. Percentage of Men age 40 and Older had PSA Test within Past 2 Years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	56%	64%	55%	57%	50%	60%	57%	59%

Digital Rectal Exam

Figure 29: In the 2004/07 survey 43% of regional men indicated that they had a digital rectal exam in their life. Saratoga County reported the highest rate at 53%, while Washington County had the lowest rate of 38%.

Figure 30: In the 2008 survey, only men age 40 and older were asked if they ever had a digital rectal exam. The majority of regional men (80%) indicated that they had an exam, which is slightly higher than the state rate of 76%. Only Essex reported a county rate lower than the regional rate of 80%.

Figure 31: In the 2008 survey, the majority of regional men age 40 and older (61%) indicated that they had a test within the past two years which is higher than the state rate of 55%.

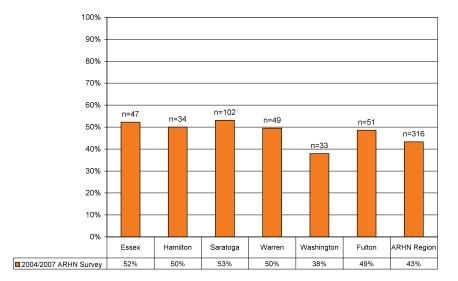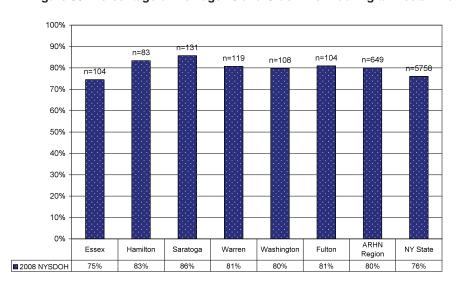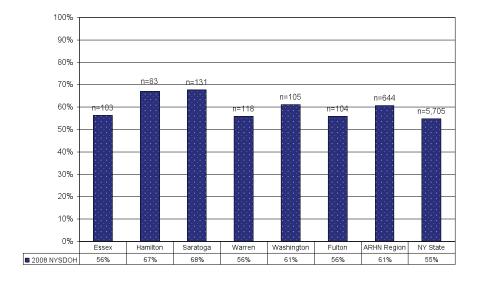**Figure 29. Percentage of Respondents Had Digital Rectal Exam at Anytime in their life**

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	52%	50%	53%	50%	38%	49%	43%

Figure 30. Percentage of Men age 40 and Older Ever Had Digital Rectal Exam

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	75%	83%	86%	81%	80%	81%	80%	76%

Figure 31. Percentage of Men age 40 and Older Had Digital Rectal Exam within past 2 years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	56%	67%	68%	56%	61%	56%	61%	55%

Home Blood Stool Test

Figure 32: In the 2004/07 survey, 39% of ARHN respondents indicated that they had a blood stool test within the past 2 years. Hamilton County had the highest rate of 45% while Warren County had the lowest rate of 34%.

Figure 33: In the 2008 survey the question was asked only to those age 50 and older. The majority (42%) of regional respondents indicated that they had ever used a home blood stool test, favorably comparing to the state rate of 35%. Hamilton County had the highest rate of 48%, while Saratoga and Warren counties had the lowest rate of 38%.

Figure 34: In the 2008 survey, a smaller percentage of regional adults age 50 and older indicated that they had used a home blood stool test within the past year (15% versus 12% for the state). Warren County had the lowest percentage at 12%, while Hamilton County had the highest percentage at 19%.

Figure 35: In the 2008 survey, 23% of regional adults age 50 and older indicated that they had used a home blood stool test in the past two years, compared to the state rate of 18%. Warren County had the lowest rate at 19%, while Hamilton County had the highest rate at 30%.

Figure 36: In the 2008 survey respondents age 50 and older were asked if they had used a home blood stool test within the past year or had a sigmoidoscopy or colonoscopy within the past ten years. The majority of regional respondents (71%) had either test comparable to the state rate of 68%.
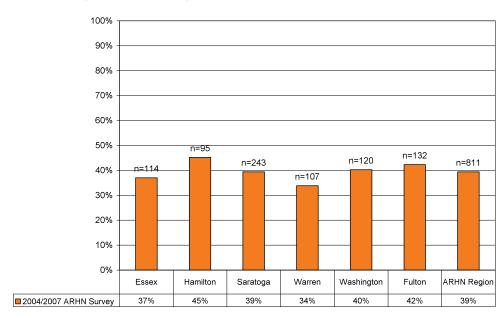
Figure 32. Percentage of Respondents Had Blood Stool Test Within Past 2 Years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	37%	45%	39%	34%	40%	42%	39%

Figure 33. Percentage of Adults Age 50 and Older Ever Used Home Blood Stool Test

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	45%	48%	38%	38%	41%	41%	42%	35%
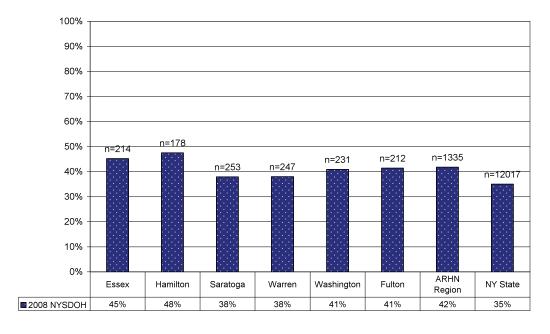
Figure 34. Percentage of Adults Age 50 and Older Used Home Blood Stool Test Within Past Year

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	17%	19%	16%	12%	16%	13%	15%	12%

n=212, n=176, n=252, n=245, n=229, n=211, n=1,325, n=11,901
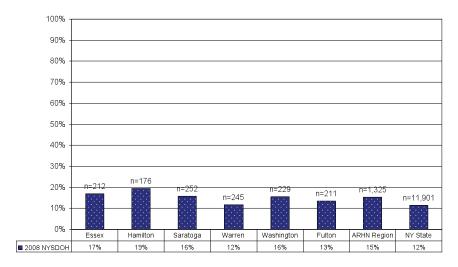
Figure 35. Percentage of Adults Age 50 and Older Used Home Blood Stool Test Within Past 2 Years

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	24%	30%	20%	19%	23%	20%	23%	18%

n=212, n=176, n=252, n=245, n=229, n=211, n=1,325, n=11,901
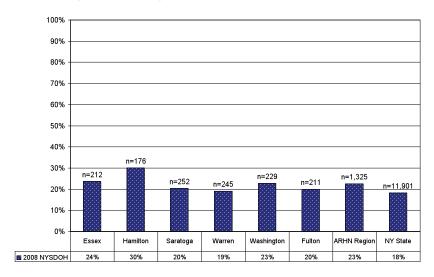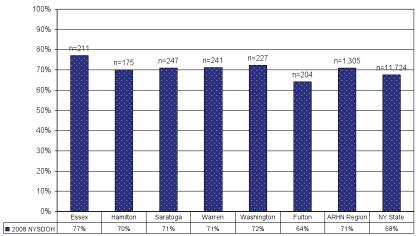
Figure 36. Percentage of Adults age 50 and Older Used Home Blood Stool Test Within Past Year or Colon Exam Within Past 10 Years*

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	77%	70%	71%	71%	72%	64%	71%	68%

n=211, n=175, n=247, n=241, n=227, n=204, n=1,305, n=11,724

*Colon exam defined as sigmoidoscopy or colonoscopy.

Colon Exam

Figure 37: In the 2004/07 survey, less than half (42%) of regional respondents indicated that they had ever had a colon exam. Fulton County had the highest rate of 53%, while Warren and Washington counties had the lowest rate of 34%.

Figure 38: In the 2008 survey, 71% of regional respondents age 50 and older indicated they ever had a sigmoidoscopy or colonoscopy as compared to the state rate of 66%. Essex County had the highest rate of 76% while Fulton County had the lowest rate of 64%.

Figure 39: In the 2008 survey, 69% of regional respondents age 50 and older indicated they had a sigmoidoscopy or colonoscopy within the past 10 years, compared to the state rate of 64%. Fulton County has the lowest rate at 62% while Essex County has the highest rate of 74%.
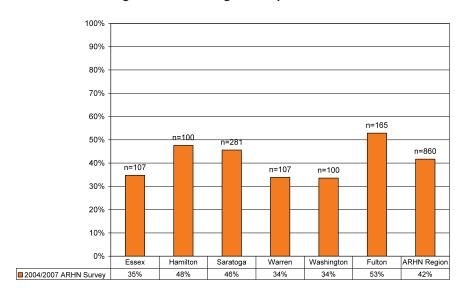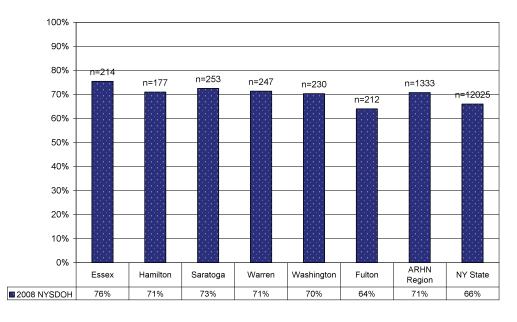
Figure 37. Percentage of Respondents Had Colon Exam

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	35%	48%	46%	34%	34%	53%	42%

(n=107, n=100, n=281, n=107, n=100, n=165, n=860)

Figure 38. Percentage of Adults age 50 and Older Ever Had Sigmoidoscopy or Colonoscopy

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	76%	71%	73%	71%	70%	64%	71%	66%

(n=214, n=177, n=253, n=247, n=230, n=212, n=1333, n=12025)

Figure 39. Percentage of Adults age 50 and Older Had Sigmoidoscopy or Colonoscopy within the past 10 years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	74%	68%	70%	69%	68%	62%	69%	64%

(n=211, n=175, n=250, n=244, n=230, n=208, n=1,318, n=11,924)

CHA Data Indicators on Access to Quality Health Care

Early stage cancer diagnosis is the only Access-related CHA data indicator identified by New York State Department of Health in their Prevention Agenda. The most recent data was for 2005.

Table 16 & 17: For the six-county area, four of the eight early stage cancer diagnosis indictors were of more concern, namely cervical, colon & rectum, ovary, and prostate cancer. The first two are among the three New York State Department of Health Prevention Agenda indicators.

Early stage cervical cancer diagnosis was the furthest of the eight cancers from the Upstate average, at 39.2% compared to 54.0% for Upstate NY; however, data was only available for two of the six counties. As compared to Upstate, the diagnosis of early stage colon and rectum cancer was less common in four of the six ARHN counties. The same was true for prostate cancer, with the majority of counties having a lower proportion of prostate cancers that were classified as early stage, as compared to Upstate. For ovary cancer early stage diagnosis, three counties had averages that were lower than the Upstate average.

Three counties -- Fulton, Warren and Washington -- had early stage cancer diagnoses that were below the Upstate average on four of the eight cancers."

Table 16. CHA Data - Access to Quality Health Care: Early Stage Cancer Diagnosis, All Counties

Percent Early Stage Cancer Diagnosis	Essex 2005	Fulton 2005	Hamilton[3] 2005	Saratoga 2005	Warren 2005	Washington 2005	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
Female breast, % early stage[1,2]	74.0	62.0	68.0	67.0	70.0	70.0	68.5	67.9	65.0	63.0	80.0	63.0
Cervical, % early stage[1,2]				43.0	27.0		35.0	39.2	54.0	51.0	65.0	53.0
Colon and rectum, % early stage[1,2]	50.0	30.0	39.0	44.0	40.0	34.0	39.5	40.7	43.0	41.0	50.0	40.0
Lung and bronchus, % early stage[2]	26.0	16.0	28.0	23.0	21.0	20.0	22.3	21.7	21.0	21.0		
Oral cavity and pharynx, % early stage	57.0	44.0		33.0	27.0	55.0	43.2	38.3	38.0	36.0		
Ovary, % early stage	16.0	22.0		15.0	21.0	15.0	17.8	16.9	19.0	19.0		
Prostate, % early stage	82.0	81.0	94.0	88.0	85.0	86.0	86.0	86.0	88.0	87.0	95.0	95.0
Melanomas of the skin, % early stage	86.0	91.0		87.0	94.0	94.0	90.4	89.5	83.0	83.0	90.0	90.0

NOTES:

☐ County or ARHN average is "Worse" than the NY Upstate average

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events results in unstable rates for Hamilton County.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives

Data Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 17. Access to Quality Health Care: Early Stage Cancer Diagnosis, ARHN Summary

Percent Early Stage Cancer Diagnosis	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Female breast, % early stage[1,2]	68.5	67.9	Similar	1	65.0	63.0	80.0	63.0
Cervical, % early stage[1,2]	35.0	39.2	**Worse**	2	54.0	51.0	65.0	53.0
Colon and rectum, % early stage[1,2]	39.5	40.7	Similar	**4**	43.0	41.0	50.0	40.0
Lung and bronchus, % early stage[2]	22.3	21.7	Similar	2	21.0	21.0		
Oral cavity and pharynx, % early stage	43.2	38.3	Similar	2	38.0	36.0		
Ovary, % early stage	17.8	16.9	Similar	3	19.0	19.0		
Prostate, % early stage	86.0	86.0	Similar	**4**	88.0	87.0	95.0	95.0
Melanomas of the skin, % early stage	90.4	89.5	Better	0	83.0	83.0	90.0	90.0

NOTES:

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0.
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average. The number of counties is highlighted in bold if more than half the counties are worse (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives

Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Prevention Quality Indicators

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs) in adult populations (age 18 and older). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

The PQIs are measured as rates of admission to the hospital for these conditions in a given population. The PQIs can be used as a starting point for evaluating the overall quality of primary and preventive care in an area. They are sometimes characterized as "avoidable hospitalizations," but this does not mean that the hospitalizations were unnecessary or inappropriate at the time they occurred. Calculation of the PQI data is defined in the Methodology section.

Figures 40-49 show the data for each Prevention Quality Indicator by county.

Figure 40: Overall, the ARHN region was below the state total for all the PQI conditions. Essex, Fulton, Hamilton, and Warren counties all had totals for all PQI conditions over the state benchmark. For the region Chronic Obstructive Pulmonary Disease is 38% above the New York State benchmark and Bacterial Pneumonia is 2% above the New York State benchmark. All other indicators are near or below the NYS standard.

Figure 41: Essex, Fulton, Hamilton and Warren counties all exceed the benchmarks for pneumonia. The ARHN Region fell below the benchmark as did Saratoga and Washington counties.

Figure 42: Hospitalization rates for dehydration in Fulton and Hamilton counties far exceed the ARHN region rates. Saratoga and Washington counties as well as the ARHN Region fell below the state benchmark.

Figure 43: With the exception of Saratoga, which was only slightly higher, all counties in the region were either at or below the New York State benchmark for Urinary Tract Infection. Hamilton County had a rate well below the state and region.

Figure 44: Essex, Fulton, Hamilton, and Warren counties well exceeded the New York State benchmarks for Chronic Obstructive Pulmonary Disease (COPD). Saratoga was the only county below the state benchmark.

Figure 45: The ARHN region and all counties fell below the New York State benchmark for Asthma. Fulton, Hamilton, and Warren counties had rates higher than the regional total.

Figure 46: Essex and Fulton counties fell somewhat above the benchmark for Angina, with the regional total and other counties falling well below the benchmark.

Figure 47: Rates for Congestive Heart Failure were comparable to the state benchmark, with Essex, Fulton, and Hamilton counties slightly above.

Figure 48: The regional total and all counties fell well below the New York State benchmark for Hypertension. Hamilton and Washington counties had the lowest rates.

Figure 49: The ARHN region and all counties also fell below the benchmark for Diabetes. All rates were similar with Essex County reporting the highest rate and Fulton County the lowest.
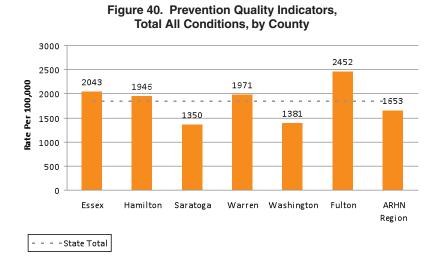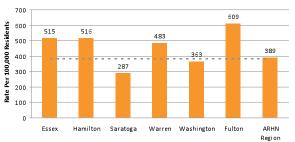
Figure 40. Prevention Quality Indicators, Total All Conditions, by County

**Figure 41. Prevention Quality Indicator,
Bacterial Pneumonia**

**Figure 42. Prevention Quality Indicator,
Dehydration**

**Figure 43. Prevention Quality Indicator,
Urinary Tract Infection**

Figure 44. Prevention Quality Indicator, COPD

Figure 45. Prevention Quality Indicator, Asthma

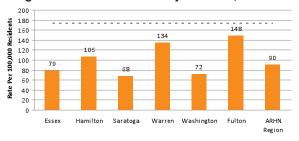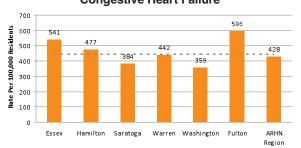**Figure 46. Prevention Quality Indicator, Angina**

**Figure 47. Prevention Quality Indicator,
Congestive Heart Failure**

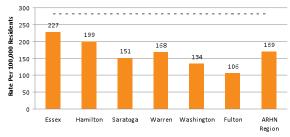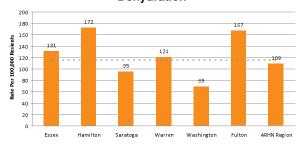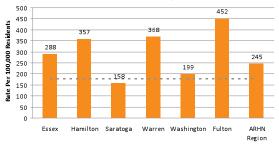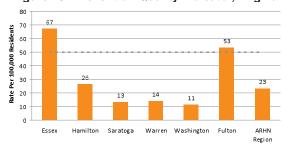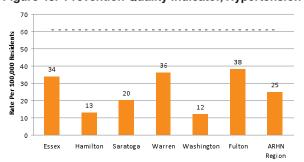**Figure 48. Prevention Quality Indicator, Hypertension**

Figure 49. Prevention Quality Indicator, Diabetes

All figures on this page

- - - - New York State

Long Term Care

Nursing homes are places to live where care is available for people who need 24-hour nursing care and supervision outside of a hospital. Although all nursing homes must provide certain basic services, some homes provide special care for certain types of clients. For example, some homes provide services for the head injured, some for those who are ventilator-dependent, some for people with AIDS and some specialize in the care of children.

In 2008 New York State nursing homes were compared against national averages in key quality measure areas. In the 15 measures, New York State received at least four out of five stars in eight of the indicators. http://nursinghomes.nyhealth.gov/ny2nat.php

In 2007 the estimated average New York State Nursing Homes rates ranged from a low of $83,256 per year in the Central Region to a high of $130,224 in Long Island. The Adirondack Region was part of the 15 counties included in the Northeastern Region which averaged $93,192 per year. http://www.health.state.ny.us/facilities/nursing/estimated_average_rates.htm

Table 18: Occupancy rate is commonly used as an indicator for the level of utilization, performance, and profitability of nursing homes, assisted living, and other long-term care facilities. In the Adirondack Region there are eighteen (18) nursing homes in five-counties with a total of 2,455 available beds (Hamilton County has no nursing homes). There are negligible noticeable geographic variations in nursing home occupancy rates in the six-county Adirondack Region.

Figure 50: In the 2004/07 survey, 12% of regional respondents indicated that they were caregivers for a person who required special care to include someone who is disabled or an elderly person. The results were consistent across counties.

Table 19: Respondents from the 2004/07 ARHN survey who indicated that they were a caregiver were asked what the primary disability was of the person in their care. Approximately one in four (27%) are caring for someone with a physical disability, 12% are caring for someone with a mental disability, 22% are caring for someone who is elderly, and 38% are caring for someone with a combination of disabilities.

Table 20: In the 2004/07 survey the majority (73%) of regional respondents who are care-givers are able to have the necessary care received within their home.

Figure 51: In the 2004/07 survey, most regional respondents (87%) feel the person in their care is receiving the care they need. All of the respondents in Hamilton County feel the person in their care is receiving the care they need.

Table 21: Of those indicating they did not feel the person in their care was receiving the care they need, 25% indicated they "cannot find the services" and 31% indicated it was because of "Cost, no insurance coverage or only partial coverage.

Table 18. Nursing Home Occupancy Rates 2005-2007, County Compared to State

County	# of Beds	Occupancy Rates			Statewide Occupancy Rates		
		2005	2006	2007	2005	2006	2007
Essex		2005	2006	2007	2005	2006	2007
Adirondack Medical Center-Uihlein	156	82.9%	80.2%	75.0%	93.9%	94.3%	94.2%
Heritage Commons Residential Health Care	84	97.5%	97.8%	97.6%	93.9%	94.3%	94.2%
Horace NYE Home	100	97.7%	99.0%	98.4%	93.9%	94.3%	94.2%
Fulton		2005	2006	2007	2005	2006	2007
Fulton County Residential Health Care Facility	176	97.4%	96.2%	n/a	93.9%	94.3%	94.2%
Nathan Littauer Hospital Nursing Home	84	99.1%	99.3%	99.2%	93.9%	94.3%	94.2%
Wells Nursing Home, Inc.	100	95.6%	94.7%	98.8%	93.9%	94.3%	94.2%
Saratoga		2005	2006	2007	2005	2006	2007
Saratoga Care Nursing Home	72	92.8%	93.6%	91.7%	93.9%	94.3%	94.2%
Saratoga County Maplewood Manor	277	97.3%	98.0%	98.2%	93.9%	94.3%	94.2%
Schuyler Ridge A Residential Health Care Facility	120	97.8%	98.5%	98.1%	93.9%	94.3%	94.2%
Wesley Health Care Center, Inc.	356	97.4%	97.4%	97.3%	93.9%	94.3%	94.2%
Warren		2005	2006	2007	2005	2006	2007
Adirondack Tri-County Nursing and Rehabilitation Center, Inc.	82	97.9%	97.2%	97.1%	93.9%	94.3%	94.2%
The Pines at Glens Falls Center for Nursing & Rehabilitation	120	95.0%	93.6%	93.0%	93.9%	94.3%	94.2%
The Stanton Nursing and Rehabilitation Centre	120	95.6%	94.9%	93.7%	93.9%	94.3%	94.2%
Westmount Health Facility	80	98.8%	99.0%	99.2%	93.9%	94.3%	94.2%
Washington		2005	2006	2007	2005	2006	2007
Fort Hudson Nursing Center, Inc.	196	97.7%	97.5%	97.2%	93.9%	94.3%	94.2%
Indian River Rehabilitation and Nursing Center	122	95.6%	97.5%	93.2%	93.9%	94.3%	94.2%
Pleasant Valley	122	98.5%	98.3%	97.3%	93.9%	94.3%	94.2%
The Orchard Nursing and Rehabilitation Centre	88	90.8%	90.2%	87.7%	93.9%	94.3%	94.2%

NOTE: Hamilton County does not have a Nursing Home
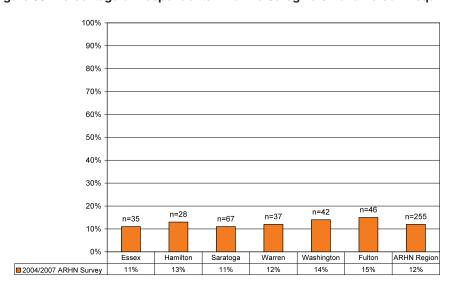Source: New York State Nursing Home Profile: http://nursinghomes.nyhealth.gov/

Figure 50. Percentage of Respondents Who Are Caregivers For a Person Requiring Special Care*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
■ 2004/2007 ARHN Survey	11%	13%	11%	12%	14%	15%	12%

*Special Care to include someone who is disabled or an elderly person

Table 19. Primary Type of Disability for which Respondents are Caregivers, by County

Is that person primarily physically disabled, mentally disabled, elderly, or a combination of those?

		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
Physically disabled	Count	8	9	19	9	13	10	68
	%	22.9%	32.1%	28.4%	24.3%	31.0%	21.7%	26.7%
Mentally disabled	Count	4	3	11	2	6	4	30
	%	11.4%	10.7%	16.4%	5.4%	14.3%	8.7%	11.8%
Elderly	Count	10	9	11	10	6	10	56
	%	28.6%	32.1%	16.4%	27.0%	14.3%	21.7%	22.0%
Combination of the above	Count	12	7	25	16	15	21	96
	%	34.3%	25.0%	37.3%	43.2%	35.7%	45.7%	37.6%
DON'T KNOW/NOT SURE	Count	1	0	1	0	2	1	5
	%	2.9%	.0%	1.5%	.0%	4.8%	2.2%	2.0%
Total	Count	35	28	67	37	42	46	255
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 20. Level of Care Received by Persons who Respondents are Caregivers

Can they receive the care they need at home, or do they require out of home care?

		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
In home care	Count	25	22	52	23	33	31	186
	%	71.4%	78.6%	77.6%	62.2%	78.6%	67.4%	72.9%
Out of home care [nursing home, day care]	Count	6	1	9	8	7	7	38
	%	17.1%	3.6%	13.4%	21.6%	16.7%	15.2%	14.9%
Both	Count	3	3	5	4	1	6	22
	%	8.6%	10.7%	7.5%	10.8%	2.4%	13.0%	8.6%
DON'T KNOW/NOT SURE	Count	1	2	1	1	0	2	7
	%	2.9%	7.1%	1.5%	2.7%	.0%	4.3%	2.7%
REFUSED	Count	0	0	0	1	1	0	2
	%	.0%	.0%	.0%	2.7%	2.4%	.0%	.8%
Total	Count	35	28	67	37	42	46	255
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
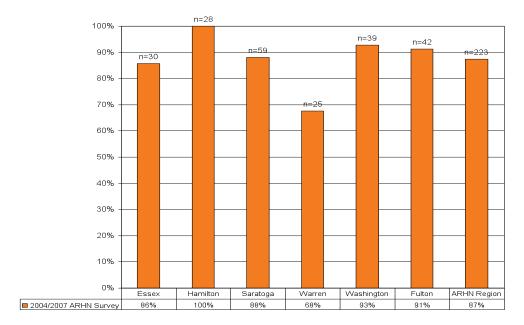
Figure 51. Percentage of Caregivers who Feel the Person in Their Care is Receiving the Care they Need

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	86%	100%	88%	68%	93%	91%	87%

Table 21. Main Reason Caregivers Do Not Feel Those in Their Care are Getting What they Need

What is the main reason that they are not getting the care they need?		Essex	Saratoga	Warren	Washington	Fulton	Total
Cannot find the services	Count	3	1	4	0	0	8
	%	60.0%	12.5%	33.3%	.0%	.0%	25.0%
Cost: No insurance coverage or only partial coverage.	Count	2	3	2	2	1	10
	%	40.0%	37.5%	16.7%	66.7%	25.0%	31.3%
DON'T KNOW/NOT SURE	Count	0	1	5	0	1	7
	%	.0%	12.5%	41.7%	.0%	25.0%	21.9%
REFUSED	Count	0	3	1	1	2	7
	%	.0%	37.5%	8.3%	33.3%	50.0%	21.9%
Total	Count	5	8	12	3	4	32
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Physicians Supply and Distribution in New York, 2006

Table 22: A challenge to access to healthcare in the six county region is physician supply, as indicated from the report New York Physician Supply and Demand through 2030: Executive Summary from the Center for Health Workforce Studies, School of Public Health, University at Albany. Other than General Surgery, the six-counties of the ARHN region shows significantly lower physician supplies when compared to New York State.

For the ARHN region between 2002 and 2006, the Mohawk Valley (includes Fulton County) experienced a 4% decline in physicians per 100,000 population. The Capital District (includes Saratoga, Warren & Washington counties) experienced a physician per 100,000 population growth of 3% or less. The report also notes that between 2002 and 2006 the number of primary care physicians per 100,000 population grew in many regions, although the North Country (includes Essex and Hamilton counties) showed a 5% decline. While not an indicator tracked in the New York State Prevention Agenda, these statistics are a strong indicator for access in the region

Other New York State physician demographics noted in the report included:

- 70% of active patient care physicians practicing in New York State in 2006 were male;
- The average female practicing was younger at 47.1 compared to male at 52.8;
- 70% were non-Hispanic Whites with underrepresented minorities (URMs) comprising 10% of the workforce while URMs made up 35% of the NYS population;
- 38% were graduates of medical schools located in NYS;
- 36% were international medical graduates;
- 80% were certified by the nationally recognized American Board of Medical Specialties of their principal specialty.

Table 22. Physician Supply and Distribution in New York, 2006

Number of Active Patient Care Physicians per 100,000 Population by Region

Specialty	Capital District	Central New York	Finger Lakes	Hudson Valley	Long Island	Mohawk Valley	New York City	North Country	Southern Tier	Western New York	New York (Total)
Primary Care	84	72	91	98	100	66	114	65	82	77	99
Non-Primary Care	170	179	172	217	248	99	273	116	153	158	226
Obstetrics/ Gynecology	13	15	14	17	18	7	21	12	13	12	18
Internal Medicine Specialties	35	32	31	35	55	15	56	13	26	27	45
General Surgery	7	8	7	8	9	6	9	8	9	8	8
Surgical Subspecialties	32	37	27	36	41	18	40	21	31	31	36
Facility Based	30	35	34	36	49	22	43	22	33	30	39
Psychiatry	19	17	19	43	25	15	46	14	17	13	33
Other Specialties	34	35	40	42	51	16	58	26	24	37	47
Total (Primary Care and Non-Primary Care fields)	254	251	263	315	348	165	387	181	235	235	325
Source: New York Physician Supply and Demand through 2030 Executive Summary. The Center for Health Workforce Studies. School of Public Health, University at Albany, SUNY. http://chws.albany.edu											

☐ *Denotes areas of specialties that make up the Non-Primary Care Specialty

☐ The Capital District Region is made up of the following counties: Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren and Washington.

☐ The North Country Region is made up of the following counties: Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, and St. Lawrence.

☐ The Mohawk Valley Region is made up of the following counties: Fulton, Herkimer, Madison, Montgomery, Oneida, and Schoharie.

Ideas Generated from Focus Groups

The following lists include information related to Access to Quality Healthcare that were generated during the focus groups. Participants were asked to vote for the ideas that they felt were top priorities for the region. The ideas were then clustered into themes.

The theme of Doctors/Providers (95) received the highest number of votes, with ideas related to creating a free clinic, better access/more affordable health care, and availabilty and location of necessary medical services.

The theme of transportation received the second highest number of votes (66) with the key single ideas noted related to improving transportation, with a focus on accessibility and affordability.

Insurance (44) rounded out the top three, with the highest single item related to universal health care.

The key theme among these items is affordability.

A complete listing of ideas by theme follows.

Doctors/ Providers (95)

- Create a free clinic - encourage/ require doctors to donate their time towards one (34)
- Make better health care more easily available (12)
- We need more affordable, accessible health care (10)
- Family planning clinic (6)
- Doctors you can call and talk to (5)
- Cross train health care providers (5)
- More doctors in the area (4)
- Develop or buy posters and pamphlets for waiting rooms on how to speak with your doctor/ ask the right questions (3)
- PA's or nurses to be able to go to homes and recommend to physicians what is needed (3)
- Encourage local medical group to expand services (3)
- More affordable continuing education for providers and the workplace allowing time (3)
- Encourage providers to refer patients for specific teaching/counseling (1)
- Request Hudson Headwaters Health Network to increase mental health service & specialty services (1)
- Increase availability of community services, health centers (1)
- Trained emergency response personnel (1)
- Educate physicians on non-medical health needs of patients (1)
- Clinics closer to this community for dental & special care (1)
- More physicians at reasonable costs to take care of our health (1)

Transportation (66)

- Improve transportation (26)
- Transportation Collaborative (5)
- Develop an accessible public transportation system (5)
- Open free bus services for at-home pick-up and drop off (4)

- More Bus Routes (3)
- Car Pools for a group of people going same places (3)
- Stop fragmenting services-support better what already exists (2)
- Senior transportation program (2)
- More available transportation on year-round basis (2)
- Change bus transportation route to drive by farmers market (1)
- Expand transportation services to link communities and services (1)
- Cheaper public transportation (1)
- Include bike lanes on all new roads (1)
- Carpool (1)
- Ask county to supply public transport (1)
- Transportation system-county wide (1)
- More community buses/bus stops provided (1)
- Safe driver program (1)
- Bus/taxi service (1)
- Begin an adequate public transport system (1)
- Free public transportation (1)
- Monthly fee for transportation to cut/even out costs - i.e.: $10/ month for as many trips (1)
- Stipend for van drivers, small charge for services to use county transportation(1)

Insurance (44)

- Universal comprehensive health care (13)
- Move to a single payer health system- Simpler, decreased non productive overhead, reorder system priorities (7)
- Free Health Insurance (5)
- Nationalize the health care system. Pharmaceutical research is too important to be done in the private sector. Create citizen forums to identify areas of research we feel need public support (4)
- 5 years with same establishment, that establishment must pay for 30% of healthcare costs for family even if part-time or temporary - a percentage that will increase over time (4)
- One application process for any/all health care plans - then it would be directed to insurance coverage that was appropriate (2)
- Program for chronically ill to receive extra aid (2)
- Health care for all kids (2)
- Insurance companies pay for prevention programs (2)
- Insurance companies- more incentives for preventative care i.e. gym membership (1)
- Insurance - affordable for middle income (1)
- Promotion of better reimbursement of government payors for services/ care necessary (1)

Technology (33)

- A healthy vision for the community website (9)
- Develop uniform 911 system (7)
- Establish online medical records - life-saving, less medical costs (4)
- Use technology to provide training (4)
- Develop system for life line for those in need (2)
- Create Education on Importance of Technology (2)
- Increase availability of medical services - portable X-rays/ CT/ MRI (2)
- Creation of electronic medical record infrastructure to ensure continuity & quality of care (2)
- Increasing the availability of web training (1)

Elder Care (29)

- More money to senior centers to help provide more services for seniors (6)
- Friendly Visiting Program in partnership with senior groups (5)
- More legislation to help seniors (4)
- Health training for caregivers (3)
- Better communication – from children, teenagers, young & middle-aged adults toward senior citizens (2)
- Nursing homes – better conditions (2)
- Assisted living. Retire in the Adirondacks (1)
- More community involvement with the elderly (1)
- We need a stronger, better-funded Office for Aging to coordinate all efforts and information for seniors (1)
- Get the young more involved with seniors (1)
- Elderly follow-up care, continuity of care – homebound program (1)
- Establish an updated list of home health aides that one can call on for their elderly parents (1)
- Establish home health clinics for elderly (1)

Hospitals (17)

- Better service for emergency rooms for people that need it (9)
- Provide health navigators in health centers and hospitals (8)

Resources & Referral Networks (13)

- Develop a brochure to list all the agencies in Fulton County for help and assistance (5)
- Identify high need groups and educate about available services/ opportunities (2)
- Evaluate and identify resources (2)
- Promote use of health care resource directory (1)
- Develop a directory of available resources (1)
- Collect comprehensive list of community resources (1)
- Create outreach networking through clubs (1)

Pharmacy (11)

- Encourage therapeutic remedies instead of prescription drugs in less serious cases (5)
- Create a system for mail-order pharmacy access (3)
- Incentives for pharmacists/pharmacies to locate here and doctors (2)
- Centralized medication resource center - for people unable to afford to purchase meds (1)

Screenings/Prevention (9)

- Design and implement prevention interventions that reach all community members (5)
- Create community health providers "networks, task groups" with representation from all health providers (hospitals, communities, health organizations, etc.) Meet 1x/month (2)
- Health care mentoring (1)
- Forced STD testing (1)

Vans/ Mobile Health Care (7)

- More mobile health vans (6)
- Provide "teen mobile" trucks - deliver STD, pregnancy and teen dating violence (TDV) screenings to youth (and counseling) (1)

Health Literacy (5)

- Establish a health literacy center for providers and consumers (2)
- Offer financial literacy classes (2)
- Use the K-I-S-S method - keep it simple stupid (1)

Dental Care (4)

- Local dentist (4)

Chronic Disease

Cardiovascular and Cerebrovascular Disease

Figure 52: In the ARHN region, 9% of respondents to the 2008 survey indicated that they had been diagnosed with cardiovascular disease by responding to the question that they had been told that they had a heart attack, stroke or angina. This is comparable to the state rate of 8%. There was little variability in the county-level rates, although Essex and Saratoga reported rates of 11%, while Fulton and Hamilton reported rates of 8%.

Figure 53: In the 2008 survey, 7% of regional respondents indicated that they had coronary heart disease, by responding to the question that they had been told that they had a heart attack or angina. This is equivalent to the state rate of 6%. All counties had rates of either 7% or 8%.

Figure 54: In the 2008 Survey, the ARHN region reports 31% of the population indicating that they have high blood pressure, compared to a state rate of 26%. The rates appear to be equivalent to the rates reported in the 2004/07 survey. Fulton County reported the highest rate at 34%, while Saratoga County reported the lowest county rate at 27%.

Figure 55: In the 2008 survey, of those who had been told that they had high blood pressure, the majority (77%) reported that they are currently taking high blood pressure medication. This is somewhat lower than the state rate of 80%. Hamilton and Warren counties did not meet report criteria for the 2008 New York State Department of Health report in terms of respondents taking high blood pressure medication and therefore are not included in this report.

Figure 52. Percentage of Adults with Cardiovascular Disease*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	11%	8%	11%	9%	9%	8%	9%	8%

n=315, n=237, n=367, n=325, n=330, n=320, n=1,894, n=18,115

*Defined as having ever been told by a health professional the respondent had a heart attack, stroke or angina
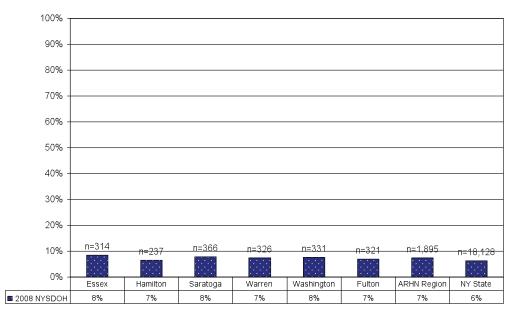
Figure 53. Percentage of Adults with Coronary Heart Disease*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	8%	7%	8%	7%	8%	7%	7%	6%

n=314, n=237, n=366, n=326, n=331, n=321, n=1,895, n=18,128

*Defined as having ever been told by a health professional the respondent had a heart attack or angina
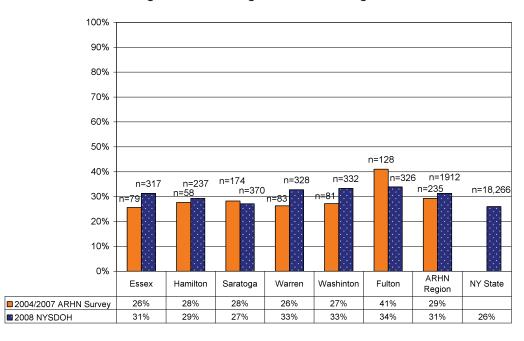
Figure 54. Percentage of Adults With High Blood Pressure

	Essex	Hamilton	Saratoga	Warren	Washinton	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	26%	28%	28%	26%	27%	41%	29%	
2008 NYSDOH	31%	29%	27%	33%	33%	34%	31%	26%

n=79, n=317, n=58, n=237, n=174, n=370, n=83, n=328, n=81, n=332, n=128, n=326, n=235, n=1912, n=18,266
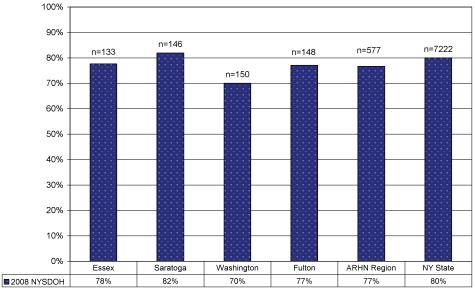
Figure 55. Percentage of Adults with High Blood Pressure Currently Taking Blood Pressure Medication

	Essex	Saratoga	Washington	Fulton	ARHN Region	NY State
■2008 NYSDOH	78%	82%	70%	77%	77%	80%

*Hamilton and Warren Counties did not meet report criteria for the 2008 NYSDOH report in terms of respondents taking high blood pressure medication and therefore are not included in this figure.
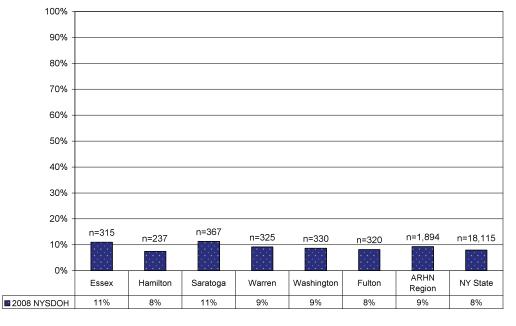
CHA Data Chronic Disease Indicators for Cardiovascular & Cerebrovascular Disease

There were 21 CHA Data Indicators for Chronic Disease, divided into four sets of tables with two tables in each set.

Cerebrovascular (Stroke) and Heart Disease Mortality

Table 23: There are five indicators displayed and one was found to be of most concern: cerebrovascular disease mortality. It is also one of the NYS DOH Prevention Agenda indicators. The county mortality rates for that disease were all consistently higher than the Upstate average for each county with the exception of Warren County. The rates in Fulton County were consistently higher than the Upstate average for all of the indicators across all three years.

Table 24: Cerebrovascular disease mortality was the only one among the five indicators where the ARHN 6-county average exceeds the average for Upstate NY, with 40.1 deaths per 100,000 residents in the ARHN area. Cardiovascular disease mortality resulted in the most deaths among the four indicators, with 258.6 deaths per 100,000 for the ARHN area.

Cardiovascular & Cerebrovascular Premature Mortality

Table 25: Five of the six ARHN-area counties had measurements of concern on the first two indicators listed. The exception was Saratoga County, which had measurements that were consistently better than the Upstate average. The trend in premature mortality is less than favorable, with some counties experiencing an increasing rate of premature mortality.

Table 26: The averages for the ARHN area give somewhat of a mixed message. The weighted average shows that the ARHN area is either similar to or better than the Upstate average on each of the five indicators, due in large part to the incidence rates in Saratoga County. On the other hand, the straight average of the rates for each of the six counties reveals consistently higher rates of premature mortality on four of the five indicators. The greater distance to the closest hospital in the more rural counties likely plays a role in the difference between the two sets of averages.

Cardiovascular & Cerebrovascular Pre-Transport Mortality

Table 27: The pre-transport mortality data on many of the same indicators reveals that while Saratoga County continues to have better than average rates, the other counties tend to experience higher than average pre-transport mortality for these conditions. The pre-transport mortality weighted average for congestive heart failure and for cerebrovascular disease both slightly exceed the Upstate average.

Table 28: Those same two indicators had a majority of counties (four or five counties) that were worse than the Upstate average. The indicator resulting in the most deaths was cardiovascular disease pre-transport mortality, at 145.3 per 100,000 residents

Cardiovascular & Cerebrovascular Hospitalizations

Table 29: While none of the counties have hospitalization rates that were higher than the Upstate average for the most recent year available (2006), that may not be a favorable finding. Since the mortality rates for some of these same diseases were shown to be higher than the Upstate average, it would seem logical that the hospitalization rates should also be higher. Cardiovascular disease is one example. While its premature mortality rate exceeds the Upstate average in five of the six ARHN counties in 2006, none of the six counties had hospitalization rates for cardiovascular disease in 2006 that exceeded the Upstate average.

Table 30: Hospitalization rates for these diseases were below the Upstate average almost across the board, especially for the most recent year's data in 2006. These are diseases that do not always provide much warning and the warning signs that do occur are sometimes ignored until it is too late, as evidenced in part by higher than average rates of premature and pre-transport mortality.

Table 23. Chronic Disease: Cerebrovascular (Stroke) and Heart Disease Mortality, All Counties

Mortality	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006					
Cerebrovascular (Stroke) disease mortality (per 100,000)[1,2]	68.3	56.3	48.8	40.2	42.8	39.7	45.1	44.7	37.6	43.1	41.1	40.4	38.9	36.7	32.7	44.7	44.9	41.9	40.2	40.1	37.0	30.5	24.0
Cardiovascular disease mortality (ICD10 I00-I99) (per 100,000)[2]	295.7	279.0	277.4	314.7	305.2	293.4	271.3	283.9	278.5	262.5	257.6	253.3	249.6	250.4	231.1	297.7		262.1	266.0	258.6	278.5		
Coronary heart disease mortality (ICD10 I11, I20-I25) (per 100,000)[2]	158.3	144.9	144.5	208.4	194.3	178.5	156.3	174.5	183.0	152.2	151.4	147.3	129.5	132.9	123.1	170.1	161.8	144.9	153.6	147.4	171.7		
Diseases of the heart mortality (ICD10 I00-I09, I11, I13, I20-I51) (per 100,000)[2]	198.4	193.0	211.8	252.4	237.7	231.5	205.7	218.8	221.5	196.6	193.1	197.3	179.6	183.4	175.9	224.8	213.3	203.0	206.8	200.7	223.3		
Congestive heart failure mortality (ICD10 I50) (per 100,000)	10.1	11.7	19.9	15.9	14.2	17.5	20.3	12.2	15.4	12.0	11.6	13.0	16.8	17.4	19.1	19.4		15.7	16.8	15.5	16.5		

NOTES:
▢ County average is "Worse" than the NY Upstate average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population as a whole (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 24. Chronic Disease: Cerebrovascular (Stroke) and Heart Disease Mortality, ARHN Summary

Mortality	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Cerebrovascular (Stroke) disease mortality (per 100,000)[1,2]	40.2	40.1	**Worse**	**5**	37.0	30.5	24.0	46.6
Cardiovascular disease mortality (ICD10 I00-I99) (per 100,000)[2]	266.0	258.6	Similar	1	278.5			
Coronary heart disease mortality (ICD10 I11, I20-I25) (per 100,000)[2]	153.6	147.4	Similar	2	171.7			
Diseases of the heart mortality (ICD10 I00-I09, I11, I13, I20-I51) (per 100,000)[2]	206.8	200.7	Similar	1	223.3			
Congestive heart failure mortality (ICD10 I50) (per 100,000)	16.8	15.5	Similar	3	16.5			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 25. Chronic Disease: Cardiovascular & Cerebrovascular Premature Mortality, All Counties

Premature Mortality	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]
Cerebrovascular disease premature mortality (ICD10 I60-I69) (per 100,000 ages 35-64)	10.1	6.1	14.2	10.3	10.3	14.5	28.2	28.4	28.5	5.5	7.3	7.2	11.0	14.6	13.2	18.2	14.2	12.7	15.1	10.6	11.4		
Cardiovascular disease premature mortality (ICD10 I00-I99) (per 100,000 ages 35-64)	109.6	100.0	113.8	113.5	114.8	123.6	98.6	113.6	113.9	80.2	82.0	74.1	84.3	96.2	103.5	103.8	102.1	101.6	105.1	92.3	99.6		
Coronary heart disease premature mortality (ICD10 I11, I20-I25) (per 100,000 ages 35-64)	75.1	59.2	54.9	85.5	85.3	81.4	56.3	71.0	71.2	55.2	55.0	48.9	55.0	64.5		62.3	71.1	67.3	67.7	63.0	63.0		
Disease of the heart premature mortality (ICD10 I00-I09, I11, I13, I20-I51) (per 100,000 ages 35-64)	89.3	85.7	93.5	100.2	97.1	98.9	70.4	85.2	85.4	68.0	65.6	61.1	69.7	74.3		81.8	84.0	83.8	82.0	75.3	81.7		
Congestive heart failure premature mortality (ICD10 I50) (per 100,000 ages 35-64)		2.0	1.8	2.9	1.5	1.5				0.4		0.4				1.3	1.3	1.3	1.3	0.9	2.1		

NOTES:
☐ County average is "Worse" than the NY Upstate average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population as a whole (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006

Table 26. Chronic Disease: Cardiovascular & Cerebrovascular Premature Mortality, ARHN Summary

Premature Mortality	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Cerebrovascular disease premature mortality (ICD10 I60-I69) (per 100,000 ages 35-64)	15.1	10.6	Similar	**5**	11.4			
Cardiovascular disease premature mortality (ICD10 I00-I99) (per 100,000 ages 35-64)	105.1	92.3	Better	**5**	99.6			
Coronary heart disease premature mortality age 35-64 (ICD10 I11, I20-I25) (per 100,000)	67.7	63.0	Similar	**4**	63.0			
Disease of the heart premature mortality age 35-64 (ICD10 I00-I09, I11, I13, I20-I51) (per 100,000)	82.0	75.3	Better	**4**	81.7			
Congestive heart failure premature mortality age 35-64 (ICD10 I50) (per 100,000)	1.3	0.9	Better	0	2.1			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set

Table 27. Chronic Disease: Cardiovascular & Cerebrovascular Pre-Transport Mortality, All Counties

Pretransport Mortality	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]
Disease of the heart pretransport mortality (ICD10 I00-I09, I11, I13, I20-I51) (per 100,000)	124.0	120.8	142.2	155.8	157.5	161.2	145.3	146.7	178.5	89.1	95.1	106.3	111.3	116.1	113.4	109.9	113.0	113.7	135.9	119.1	128.2		
Congestive heart failure pretransport mortality (ICD10 I50) (per 100,000)	7.7	11.1	13.8	10.9	12.0	14.4	18.9	6.4	6.4	6.4	6.0	6.8	11.8	12.3	13.2	13.5	10.6	10.6	10.9	9.8	9.5		
Coronary heart disease pretransport mortality (ICD10 I11, I20-I25) (per 100,000)	103.4	90.8	98.3	130.4	129.2	125.2	120.0	121.2	153.0	72.6	80.5	83.6	81.4	85.4	79.3	84.0	84.4	78.3	103.0	89.4	102.0		
Cardiovascular disease pretransport mortality (ICD10 I00-I99) (per 100,000)	188.9	176.5	177.5	190.2	192.9	194.8	189.5	184.9	210.4	118.2	122.5	125.8	151.4	154.5	143.4	143.8	151.3	146.5	166.4	145.3	154.8		
Cerebrovascular disease pretransport mortality (ICD10 I60-I69) (per 100,000)	47.9	36.0	24.1	21.1	20.4	21.6	18.9	12.8	19.1	17.0	15.0	14.1	21.1	20.0	18.3	20.5	27.1	24.3	20.3	18.0	17.0		

NOTES:
☐ County average is "Worse" than the NY Upstate average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population as a whole (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006

Table 28. Chronic Disease: Cardiovascular & Cerebrovascular Pre-Transport Mortality, ARHN Summary

Pretransport Mortality	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Disease of the heart pretransport mortality (ICD10 I00-I09, I11, I13, I20-I51) (per 100,000)	135.9	119.1	Better	3	128.2			
Congestive heart failure pretransport mortality (ICD10 I50) (per 100,000)	10.9	9.8	**Worse**	**4**	9.5			
Coronary heart disease pretransport mortality (ICD10 I11, I20-I25) (per 100,000)	103.0	89.4	Better	2	102.0			
Cardiovascular disease pretransport mortality (ICD10 I00-I99) (per 100,000)	166.4	145.3	Similar	3	154.8			
Cerebrovascular disease pretransport mortality (ICD10 I60-I69) (per 100,000)	20.3	18.0	Similar	**5**	17.0			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 29. Chronic Disease: Cardiovascular & Cerebrovascular Hospitalizations, All Counties

Hospitalizations	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
Coronary heart disease hospitalizations (per 10,000)[1]	41.1	38.8	37.8	67.7	62.1	58.3	64.9	55.0	46.2	55.8	52.7	48.3	62.2	59.5	55.8	65.7	58.5	56.2	50.4	50.9	59.1	61.2	48.0	
Congestive heart failure hospitalizations age 18+ (per 10,000)[1]		41.5			43.2			46.4			34.9			47.8			44.9		43.1	40.0		46.3	33.0	48.9
Congestive heart failure hospitalizations (per 10,000)	20.4	21.9	25.4	25.0	25.3	32.4	21.3	25.0	23.1	24.8	26.6	26.8	30.0	30.3	29.4	29.5	30.0	31.1	28.0	28.3	29.9			
Cardiovascular disease hospitalizations (ICD9 390-459) (per 10,000)	130.7	129.4	133.7	182.7	180.2	175.5	164.1	158.8	154.9	165.6	165.7	160.8	170.5	168.0	164.1	172.3	163.5	161.6	158.4	160.8	176.8			
Disease of the heart hospitalizations (ICD9 390-398, 402, 404-429) (per 10,000)	90.6	89.3	93.3	131.7	127.8	126.0	121.9	111.7	108.0	117.0	116.2	111.8	129.0	126.1	121.9	130.3	122.1	121.5	113.8	114.8	126.2			
Cerebrovascular disease hospitalizations (ICD9 430-438) (per 10,000)	21.0	18.8	19.0	26.4	27.9	27.5	24.5	27.6	28.9	26.3	27.5	26.7	21.8		21.9	20.9	19.9	19.5	23.9	24.4	26.8			

NOTES:
▢ County average is "Worse" than the NY Upstate or NY State average if Upstate data is not available.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is an average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average for the population as a whole (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 30. Chronic Disease: Cardiovascular & Cerebrovascular Hospitalizations, ARHN Summary

Hospitalizations	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Coronary heart disease hospitalizations (per 10,000)[1]	50.4	50.9	Better	0	59.1	61.2	48.0	
Congestive heart failure hospitalizations age 18+ (per 10,000)[1]	43.1	40.0	Better	1		46.3	33.0	48.9
Congestive heart failure hospitalizations (per 10,000)	28.0	28.3	Similar	1	29.9			
Cardiovascular disease hospitalizations (ICD9 390-459) (per 10,000)	158.4	160.8	Similar	0	176.8			
Disease of the heart hospitalizations (ICD9 390-398, 402, 404-429) (per 10,000)	113.8	114.8	Similar	0	126.2			
Cerebrovascular disease hospitalizations (ICD9 430-438) (per 10,000)	23.9	24.4	Similar	2	26.8			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references: Similar is used if the difference is less than 3.0 (30.0 if average > 100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average (or the NYS average if the Upstate value is not available). The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda
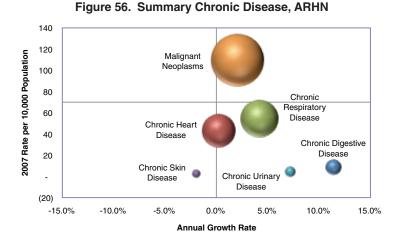
Hospitalization Rates for Various Chronic Disease Conditions in the Region

Figure 56: Illustrates the annual growth rates for various conditions noted and shows that within the Chronic Diseases category, Cancer is the most urgent priority with Respiratory Disease, and Digestive Disease emerging most rapidly. Although Urinary Disease is increasing, the volume of patients this represents is relatively small. Heart Disease, although not increasing, still affects a large number of patients in this region. Of less concern is Skin Disease which represents a small portion of the total patients and has been decreasing over time.

Figure 57: With regard to Cerebrovascular Disease, the hospital discharge data for the region over the past 7 years shows relatively stable rates of utilization, around 29 per 10,000 residents. Inpatient rates are higher, around 27 per 10,000, while ambulatory surgery rates are around 2 per 10,000 residents.

Figure 58: At the county level, there is some variability in the data regarding the inpatient Cerebrovascular Disease. Warren County had the highest utilization rates, fluctuating between 35 and 44, while Washington County has the lowest rates, fluctuating around 25 per 10,000.

Figure 59: Washington County has the highest outpatient rate, fluctuating as high as 3.5%. Warren County's rate has been close to zero the past several years. Essex County also has outpatient survey rates that are lower than average of the past 7 years. Warren County had the highest overall hospital utilization rates.

Figure 56. Summary Chronic Disease, ARHN

Figure 57. Cerebrovascular Disease Rate Per 10,000 Residents, ARHN Region

Figure 58. Inpatient Cerebrovascular Disease Rate Per 10,000 Residents, by County
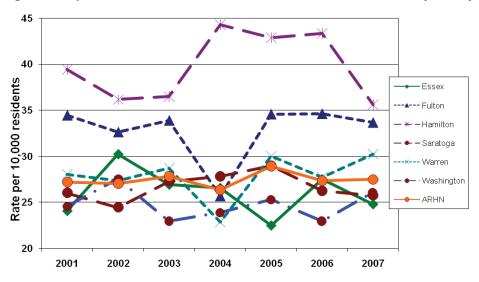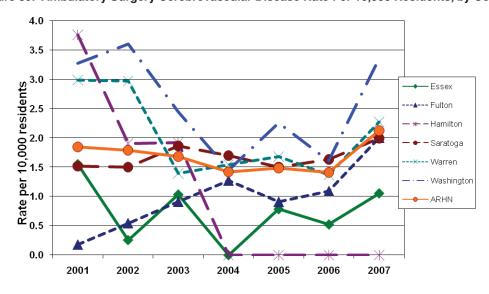

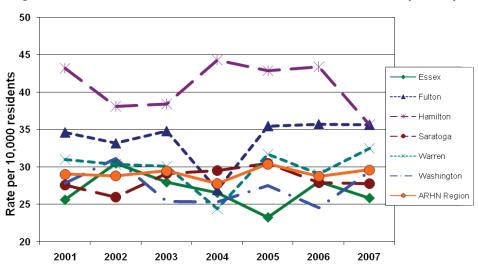**Figure 59. Ambulatory Surgery Cerebrovascular Disease Rate Per 10,000 Residents, by County**

Figure 60. Total Cerebrovascular Disease Rate Per 10,000 Residents, by County

Chronic Heart Disease

Figure 61: While the overall rates of hospital utilization for Chronic Heart Disease in the ARHN region have been somewhat stable over the past 7 years, fluctuating between 40 and 45 discharges per 10,000 residents, the inpatient rates have been declining, while the ambulatory surgery rates are increasing.

Figure 62: Inpatient rates have declined in all counties except Essex, which has remained somewhat stable around 20 per 10,000 residents. Hamilton County has had the most significant decline, from a high of almost 75 in 2001 to 40 in 2007.

Figure 63: For ambulatory surgery, county level rates are also somewhat varied, with Saratoga County generally having higher rates, fluctuating around 15 per 10,000 residents, but not increasing at a dramatic rate as some of the other counties.

Figure 64: In total, Hamilton County has rates somewhat above the other counties, while Essex County generally has rates that are lower than the other counties.
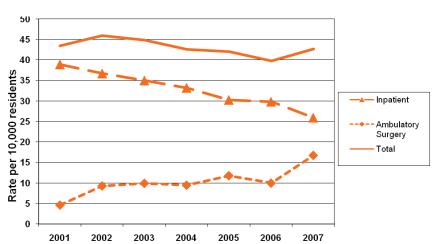
Figure 61. Chronic Heart Disease Rate Per 10,000 Residents, ARHN Region

Figure 62. Inpatient Chronic Heart Disease Rate Per 10,000 Residents, by County

Figure 63. Ambulatory Surgery Chronic Heart Disease Rate Per 10,000 Residents, by County
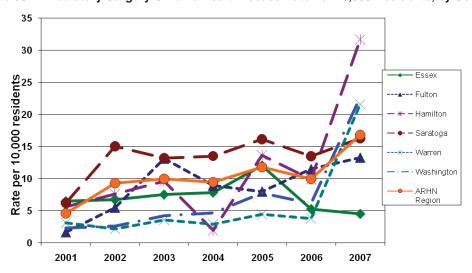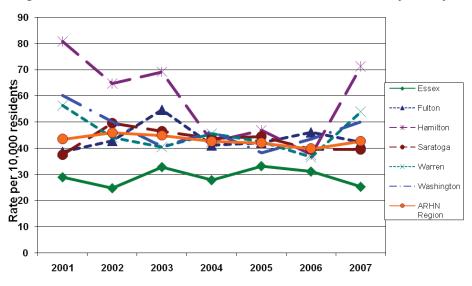

Figure 64. Total Chronic Heart Disease Rate Per 10,000 Residents, by County

Cancer

Prostate Cancer

Figure 65: At 10%, Hamilton County had the highest reported prevalence of prostate cancer of men age 40 and older among counties, which was higher than the ARHN region (5%) and state (4%). Saratoga County (1%), and Fulton County (2%), had fewer male respondents diagnosed with prostate cancer than the region or the state.
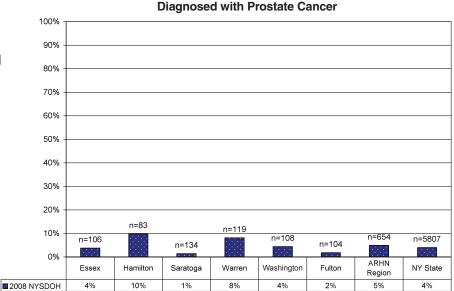
Figure 65. Percentage of Men age 40 and Older Diagnosed with Prostate Cancer

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	4%	10%	1%	8%	4%	2%	5%	4%

(n=106, n=83, n=134, n=119, n=108, n=104, n=654, n=5807)

CHA Data Chronic Disease Indicators for Cancer

There were 14 CHA Data Indicators for Cancer, presented in two sets of tables – representing Incidence and Mortality – with two tables in each set.

Cancer Incidence

Table 31: In terms of cancer incidence, the averages for the ARHN region are fairly similar to the Upstate averages although there were three cancers where the incidence was higher than average in four or more counties. Those cancers were cervical cancer, malignant mesothelioma, and oral cavity & pharynx cancer. The rate of oral cavity and pharynx cancer exceeded the Upstate rate in each of the six counties. For the most recent data available, three counties – Hamilton, Saratoga and Washington – had higher than average rates on four of the seven cancers.

Table 32: The cancers with the highest incidence for the ARHN region on average were prostate cancer at 160.3 per 100,000 residents and female breast cancer at 124.9 per 100,000 residents.

Cancer Mortality

Table 33: In terms of cancer mortality, the ARHN region average was generally below the Upstate average, with the exception of cervical cancer, where the ARHN average was 2.8 and the Upstate average was 2.2 per 100,000 residents. Five of the six ARHN counties exceeded the Upstate average for cervical cancer mortality in 2006. The one exception was Essex County, which equaled the Upstate average. Colon and rectum as well as melanoma of the skin cancer mortality rates were higher than the Upstate average in four of the six counties. With the exception of Saratoga County, each county had higher than average mortality rates on at least four of the seven cancers.

Table 34: While the cancer mortality rates for the ARHN region were generally at or below the Upstate average, the weighted ARHN average did exceed the U.S. average for five of the seven cancers listed. The average mortality rates for the region still were fairly close to the State and National averages, with the possible exception of prostate cancer. The ARHN average was 27.3 deaths per 100,000 compared to 22.8 for New York State and 24.7 for the U.S. Prostate cancer had the highest incidence of mortality at 27.3 per 100,000 residents, followed by breast cancer (23.5), colorectal (19.1), and colon & rectum (17.7).

Table 31. Chronic Disease: Cancer Incidence, All Counties

Cancer Incidence	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]
Cervix uteri cancer incidence (per 100,000)[2]	9.3	10.1		11.4	9.9		4.4	4.1		8.8	7.8		8.0	8.8		10.5	8.7		8.2	8.5	7.6		
Colon and rectum cancer incidence (per 100,000)[2]	65.5	65.5		55.8			64.6	65.3		61.3	59.4		59.7	53.6		59.2	52.4		59.2	50.8	72.7		49.0
Female breast cancer incidence (per 100,000)[2]	121.2	98.2		129.9	109.8		170.0	140.1		143.9	136.1		126.7	118.5		140.3	120.9		120.6	124.9			120.8
Malignant mesothelioma incidence (age 15+) (per 1,000,000)	12.5		6.1	22.6		17.5				27.3		19.4	11.6		18.3	16.2		19.1	16.1	17.8	16.7		15.3
Oral cavity and pharynx cancer incidence (per 100,000)	14.7	13.3		12.5	13.6		28.2	19.0		11.2	11.5		15.2	14.3		15.3	15.3		14.5	13.0	9.8		
Ovary cancer incidence (per 100,000)	17.5			12.2			22.5			14.4			14.7	14.3		18.7			16.7	15.1	15.7		13.0
Prostate cancer incidence (per 100,000)	145.9			157.9			178.5			163.9			161.1	171.5		156.4			160.6	160.3	174.4		152.9

NOTES:
☐ County average is "Worse" than the NY Upstate average, or NYS average if Upstate not available.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population as a whole (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006

Table 32. Chronic Disease: Cancer Incidence, ARHN Summary

Cancer Incidence	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Cervix uteri cancer incidence (per 100,000)[2]	8.2	8.5	Similar	5	7.6			
Colon and rectum cancer incidence (per 100,000)[2]	59.2	50.8	Better	0	72.7	49.0		48.3
Female breast cancer incidence (per 100,000)[2]	120.6	124.9	Similar	2		120.8		117.7
Malignant mesothelioma incidence (age 15+) (per 1,000,000)	16.1	17.8	Similar	**4**	16.7	15.3		18.5
Oral cavity and pharynx cancer incidence (per 100,000)	14.5	13.0	**Worse**	**6**	9.8			
Ovary cancer incidence (per 100,000)	16.7	15.1	Similar	3	15.7	13.0		12.4
Prostate cancer incidence (per 100,000)	160.6	160.3	Similar	1	174.4	152.9		142.4

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references: Similar is used if the difference is less than 3.0 (30.0 if average > 100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average (or the NYS average if the Upstate value is not available). The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 33. Chronic Disease: Cancer Mortality, All Counties

Cancer Mortality	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Breast cancer mortality (female) (per 100,000)[1,2]	17.8	15.2	12.2	30.6	30.7	32.9	35.2	24.9	23.8	25.0	23.2	21.7	31.0	31.8	26.8	21.9	23.2	24.8	23.7	23.5		24.1	21.3	24.0
Cervical cancer mortality (per 100,000 females)[1,2]	2.0	2.8	2.2	2.7	2.7	2.8		4.1	4.5	2.5	2.3	2.4	2.9	2.8	3.3	4.4	3.1	3.7	3.2	2.8	2.2	2.6	2.0	2.4
Colorectal cancer mortality (per 100,000)[1]	31.0	27.8	23.2	24.5	23.2	23.3	26.0	21.3	19.1	21.0	19.0	17.8	21.4	18.3	17.4	24.9	21.7	19.0	20.0	19.1	19.1	19.1	13.7	18.0
Colon and rectum cancer mortality (per 100,000)[2]	32.9	27.8		27.0			21.3	21.3		20.9	19.0		21.0	18.3		23.5	21.7		21.6	17.7	19.4	16.8		17.4
Melanoma of the skin mortality (per 100,000)	4.7			1.5			11.2			2.0			2.7	3.8		2.9			4.2	2.5	2.7	2.2		2.7
Ovary cancer mortality (per 100,000)	8.7			4.1			17.9			11.3			8.1	9.6		7.2			9.6	9.2	9.6	8.9		8.6
Prostate cancer mortality (per 100,000)	37.1			31.1			22.5			26.5			25.9	29.3		22.8			27.7	27.3	27.8	22.8		24.7

NOTES:

▢ County average is "Worse" than the NY Upstate average, or NYS average if Upstate not available.

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population as a whole (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives

Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006

Table 34. Chronic Disease: Cancer Mortality, ARHN Summary

Cancer Mortality	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Breast cancer mortality (female) (per 100,000)[1,2]	23.7	23.5	Similar	3		24.1	21.3	24.0
Cervical cancer mortality (per 100,000 females)[1,2]	3.2	2.8	**Worse**	**5**	2.2	2.6	2.0	2.4
Colorectal cancer mortality (per 100,000)[1]	20.0	19.1	Similar	2	19.1	19.1	13.7	18.0
Colon and rectum cancer mortality (per 100,000)[2]	21.6	17.7	Similar	**4**	19.4	16.8		17.4
Melanoma of the skin mortality (per 100,000)	4.2	2.5	Similar	**4**	2.7	2.2		2.7
Ovary cancer mortality (per 100,000)	9.6	9.2	Similar	2	9.6	8.9		8.6
Prostate cancer mortality (per 100,000)	27.7	27.3	Similar	3	27.8	22.8		24.7

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references: Similar is used if the difference is less than 3.0 (30.0 if average > 100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average (or the NYS average if the Upstate value is not available). The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives

Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Diabetes

Figure 66: The 2008 survey indicates that 10% of the regional respondents stated they have been diagnosed with diabetes which is the same rate as the state. There is a slight variability in the county data, with Washington County reporting the lowest rate of 8% and Essex, Hamilton and Warren reporting the highest rate at 11%. This is comparable with the 2004/07 survey responses.
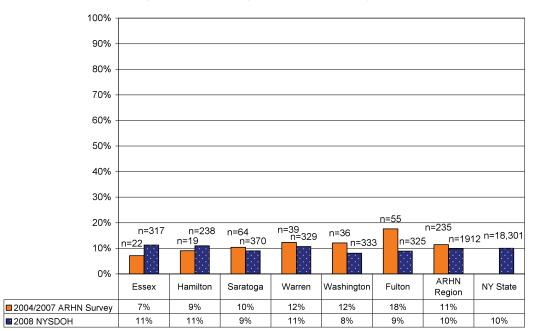
Figure 66. Percentage of Adults Ever Diagnosed with Diabetes

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	7%	9%	10%	12%	12%	18%	11%	
2008 NYSDOH	11%	11%	9%	11%	8%	9%	10%	10%

CHA Data Chronic Disease Indicators for Diabetes

Table 35 and 36: There were five CHA data indicators for diabetes.

The ARHN average rates for diabetes were generally below the averages for Upstate or New York State. The one exception was short-term complication hospitalizations for 6 to 17 year-olds, which is a New York State Department of Health Prevention Agenda priority. There were 4.0 per 10,000 residents in the ARHN region compared to 3.0 in New York State. Four of the six counties exceeded the New York average on that measure.

Diabetes mortality was another indicator where the majority of counties exceeded the Upstate average, with Saratoga and Warren counties having rates that were slightly lower than the Upstate average in 2006.

Table 35. Chronic Disease: Diabetes, All Counties

Diabetes	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Diabetes short-term complication hospitalization age 6-17 (per 10,000)[1]			3.0			10.1			5.1			2.4			4.0			4.4	4.8	4.0		3.0	2.3	2.9
Diabetes short-term complication hospitalization (per 10,000 Age 18+)[1]			3.1			2.9			0.0			3.0			3.5			4.4	3.4	3.3		5.3	3.9	5.5
Diabetes mortality (ICD10 E10-E14) (per 100,000)[2]	22.1	22.1	20.2	17.4	21.2	18.3	21.2	20.9	27.6	16.1	16.8	14.9	18.7	17.8	16.7	22.4	15.3	20.9	19.8	17.0	17.4			
Diabetes hospitalization rate (any dx ICD9 250) (per 10,000)		152.9	162.4		211.5	219.8		131.9			152.7			173.0			163.1		164.2	164.3	192.1			
Diabetes hospitalization rate (primary dx ICD9 250) (per 10,000)	11.5	12.1	12.6	14.8	15.7	15.7	4.8	7.2	9.0	9.1	9.2	9.5	9.5	9.6	10.5	10.2	10.2	11.7	10.7	10.4	14.0			

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 36. Chronic Disease: Diabetes, ARHN Summary

Diabetes	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Diabetes short-term complication hospitalization age 6-17 (per 10,000)[1]	4.8	4.0	**Worse**	**4**		3.0	2.3	2.9
Diabetes short-term complication hospitalization (per 10,000 Age 18+)[1]	3.4	3.3	Better	0		5.3	3.9	5.5
Diabetes mortality (ICD10 E10-E14) (per 100,000)[2]	19.8	17.0	Similar	4	17.4			
Diabetes hospitalization rate (any dx ICD9 250) (per 10,000)	164.2	164.3	Better	1	192.1			
Diabetes hospitalization rate (primary dx ICD9 250) (per 10,000)	10.7	10.4	Better	1	14.0			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Arthritis

Figure 67: In the 2008 survey, approximately one in three (35%) adults residing in the ARHN region indicated that they have arthritis, which is slightly higher than the state average (28%). Fulton County (40%), and Hamilton and Warren counties (37%), reported a slightly higher rate of arthritis than the region and state averages. Saratoga County (29%) had the least amount of respondents reporting that they had arthritis, with a rate similar to that of the state.

Figure 68: In the 2008 survey, adults were asked if they had chronic joint symptoms. Chronic joint systems are defined as having symptoms of pain, aching, or stiffness in or around a joint in the past 30 days and began more than 3 months ago. Almost half (49%) of the regional respondents indicated that they had some type of chronic joint symptoms, compared with the overall state rate of 43%. Washington County had the lowest percentage at 40%, whereas Warren and Fulton counties reported the highest rate of 56%.
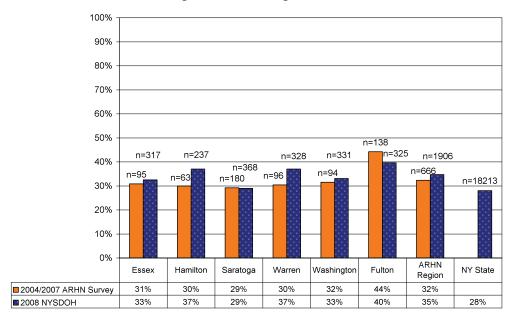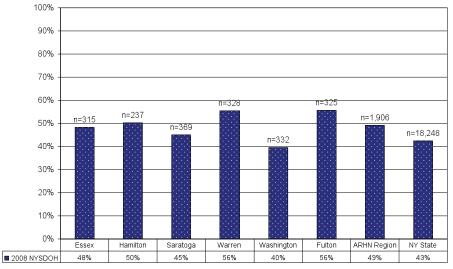
Figure 67. Percentage of Adults with Arthritis

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	31%	30%	29%	30%	32%	44%	32%	
2008 NYSDOH	33%	37%	29%	37%	33%	40%	35%	28%

Figure 68. Percentage of Adults with Chronic Joint Symptoms*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	48%	50%	45%	56%	40%	56%	49%	43%

*Defined as having symptoms of pain, aching, or stiffness in or around a joint in the past 30 days and began more than 3 months ago

Endocrinology/Nutrition/Metabolic Disease

Figure 69: Overall, regional hospital utilization rates for endocrine related conditions are slightly increasing over the last 7 years, from about 40 per 10,000 residents up to 50. Regional inpatient rates have had little fluctuation, but have increased slightly over the past 7 years from about 34 to 36 per 10,000 residents. Ambulatory Surgery rates have also remained somewhat consistent, although they increased in 2007 from 6 to 14 per 10,000 residents.

Figure 70: Fulton County has the highest inpatient and total utilization rates, while Saratoga County has the lowest inpatient utilization rates.

Figure 71: Essex County has the lowest Ambulatory Surgery utilization rates.
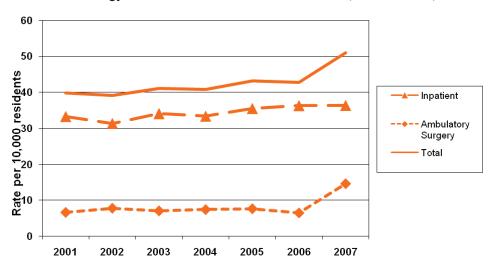
Figure 69. Endocrinology/Nutrition/Metabolic Disease Rate Per 10,000 Residents, ARHN Region

Figure 70. Inpatient Endocrinology/Nutrition/Metabolic Disease Rate Per 10,000 Residents, by County
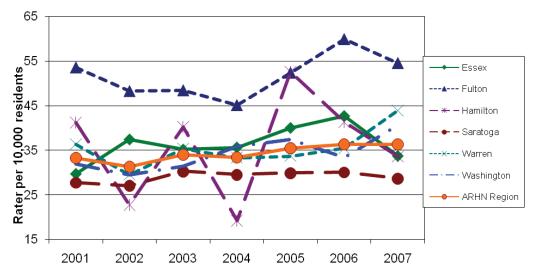
Figure 71. Ambulatory Surgery Endocrinology/Nutrition/Metabolic Disease Rate Per 10,000 Residents, by County
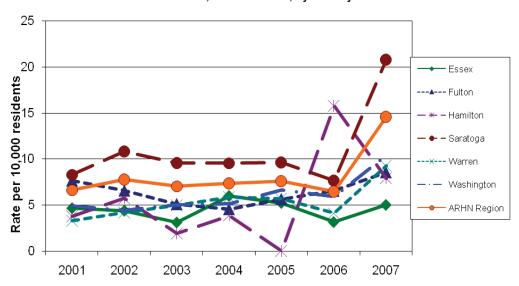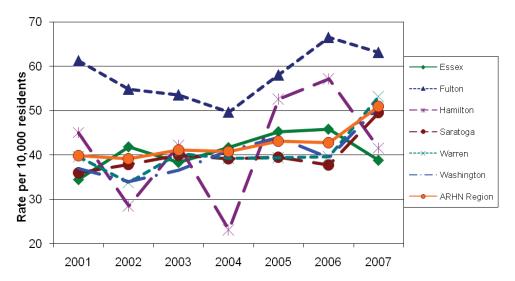
Figure 72. Total Endocrinology/Nutrition/Metabolic Disease Rate Per 10,000 Residents, by County

Blood Disease

Figure 73: Overall hospital utilization rates for Blood Diseases are increasing over the past 7 years. Ambulatory Surgery rates have increased at a higher rate than inpatient rates, which are also increasing.

Figure 74: Essex County had the highest inpatient utilization rate, while Hamilton had the lowest. All county rates are increasing in approximately the same manner, with the exception of Hamilton, which fluctuated dramatically from 2003 through 2005.

Figure 75: Saratoga County has the highest rates for Ambulatory Surgery, much higher than the other counties. All other counties tend to have rates lower than the regional average.

Figure 76: Over the past 6 years, Saratoga County has had hospital utilization rates for Blood Disease that are consistently higher than the ARHN Region. Warren County has consistently reported the lowest hospital utilization rates with the exception of 2006, where Hamilton reported the lowest utilization rates. All counties, with the exception of Essex, showed an increase in utilization rates between 2006-2007.
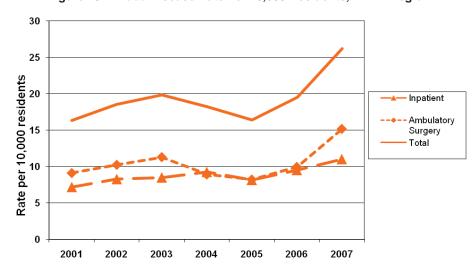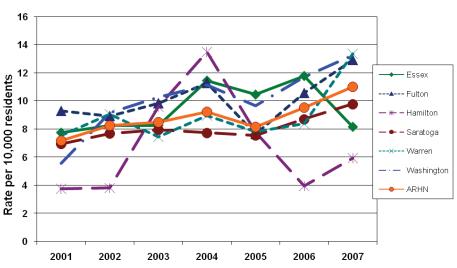
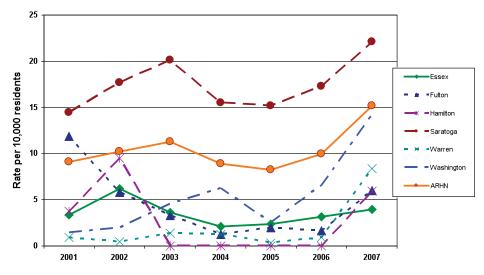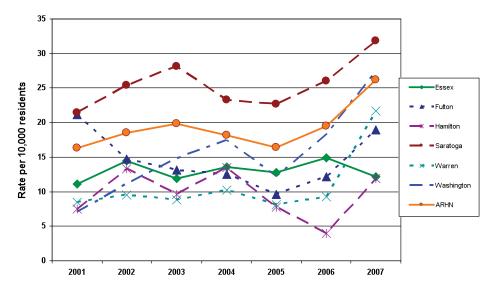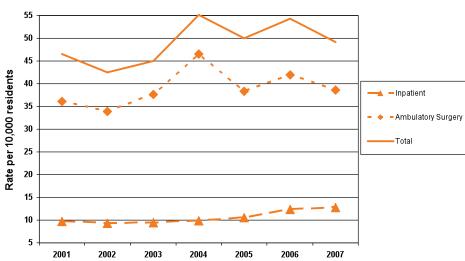**Figure 73.   Blood Disease Rate Per 10,000 Residents, ARHN Region**

Figure 74.   Inpatient Blood Disease Rate Per 10,000 Residents, by County

Figure 75. Ambulatory Surgery Blood Disease Rate Per 10,000 Residents, by County

Figure 76. Total Blood Disease Rate Per 10,000 Residents, by County

Nervous System Disease

Figure 77: The overall regional hospital utilization rates for nervous system disease fluctuated over the past 7 years, although both the overall inpatient and outpatient rates show an upward trend.

Figure 78: Fulton County has the highest inpatient utilization rates, while Essex County has the lowest rates.

Figure 79: Hamilton has the highest rates for ambulatory surgery, fluctuating over the past 7 years. Saratoga County has the lowest ambulatory surgery utilization rates.

Figure 80: In total, Saratoga and Essex counties have lower than average rates, while all other counties have rates higher than the average.

Figure 77. Nervous System Disease Rate Per 10,000 Residents, ARHN Region

Figure 78.   Inpatient Nervous System Disease Rate Per 10,000 Residents, by County
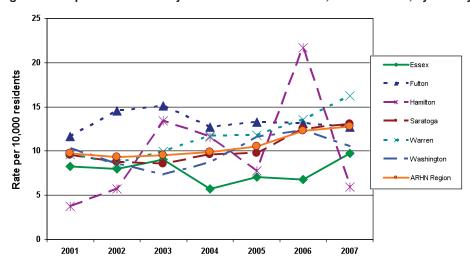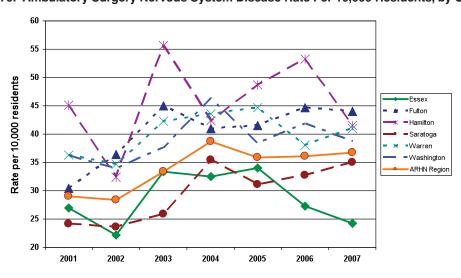

Figure 79. Ambulatory Surgery Nervous System Disease Rate Per 10,000 Residents, by County

Figure 80. Total Nervous System Disease Rate Per 10,000 Residents, by County

Other Circulatory Disease

Figure 81: Over the past 7 years, overall hospital utilization fluctuated some, then spiked in 2007 to 63 per 10,000 residents, most of this explained by increases in inpatient utilization. Inpatient utilization remained relatively stable during that period, around 24 per 10,000 residents.

Figure 82: For inpatient, most county's utilization patterns followed the average rate, although Fulton and Essex counties were somewhat higher than the average. Hamilton County's utilization rates fluctuate widely, starting at a rate of almost 44 in 2001, declining to a rate of 18 in 2007.

Figure 83: Ambulatory Surgery rates also vary widely among counties, with Fulton and Saratoga counties above the average and the remaining counties lower than the average.

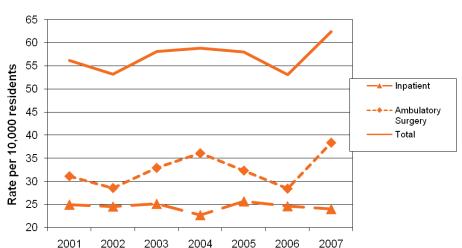Figure 84: Fulton and Saratoga counties are above the overall hospital utilization rates.

Figure 81. Other Circulatory Disease Rate Per 10,000 Residents, ARHN Region

Figure 82. Inpatient Other Circulatory Disease Rate Per 10,000 Residents, by County

Figure 83. Ambulatory Surgery Other Circulatory Disease Rate Per 10,000 Residents, by County
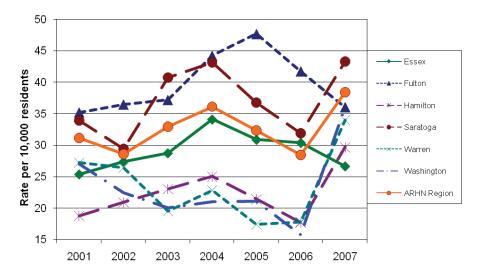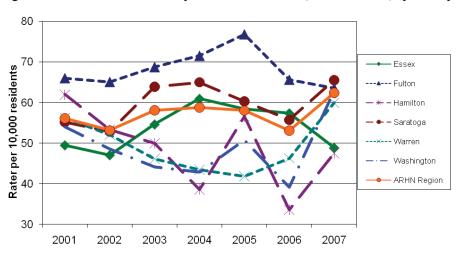

Figure 84. Total Other Circulatory Disease Rate Per 10,000 Residents, by County

Chronic Respiratory Disease

Figure 85: Overall, Chronic Respiratory Disease hospital utilization rates are increasing slightly in the region over the 7 year period. Inpatient and Ambulatory Surgery rates are following the overall pattern.

Figure 86: Inpatient utilization rates fluctuate greatly in Hamilton and Warren counties over the 7 year period. Essex and Fulton county rates are generally above the regional average, while Saratoga County rates were lower.

Figure 87: For Ambulatory Surgery, rates are generally increasing for the region, with the exception of Hamilton and Essex counties, which report lower than average rates.

Figure 88: In total Essex, Hamilton, Saratoga counties rates are lower than the averages for the last 7 years, while Fulton & Warren are above the regional rates.
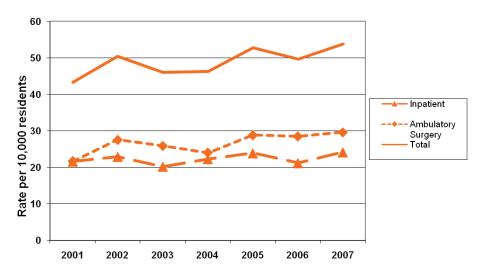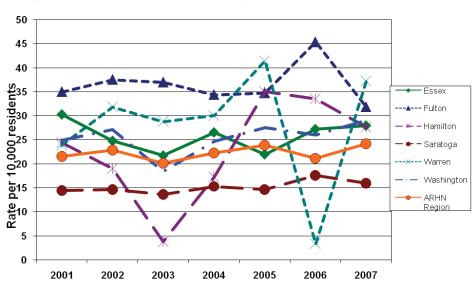
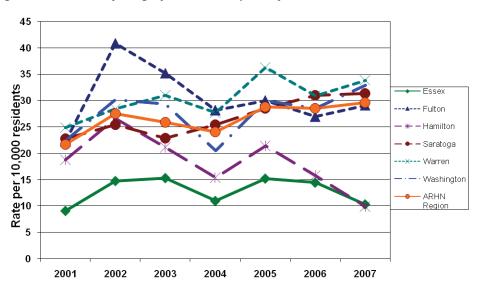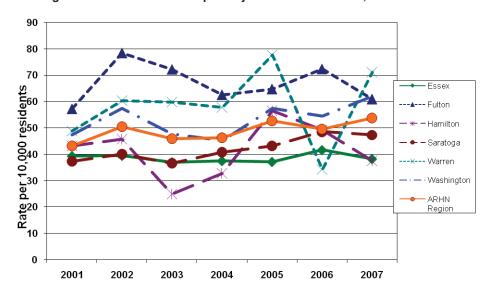**Figure 85. Chronic Respiratory Disease Rate Per 10,000 Residents, ARHN Region**

Figure 86. Inpatient Chronic Respiratory Disease Rate Per 10,000 Residents

Figure 87. Ambulatory Surgery Chronic Respiratory Disease Rate Per 10,000 Residents

Figure 88. Total Chronic Respiratory Disease Rate Per 10,000 Residents

Chronic Digestive Disease

Figure 89: Overall, Chronic Digestive Disease rates are increasing over the past 7 years in the region, as are both the inpatient and ambulatory surgery rates.

Figure 90: Inpatient utilization rates are fluctuating in some counties, most notably Hamilton and Fulton. Fulton also has higher than average rates.

Figure 91: For Ambulatory Surgery, Fulton County is generally higher than average, although the rate dropped in 2007. Hamilton County rates fluctuated the greatest from almost zero to a high of 5 per 10,000 residents.

Figure 92: In total, Fulton County generally has the highest rates, although Hamilton and Warren county rates spiked in 2007 to higher than average rates.

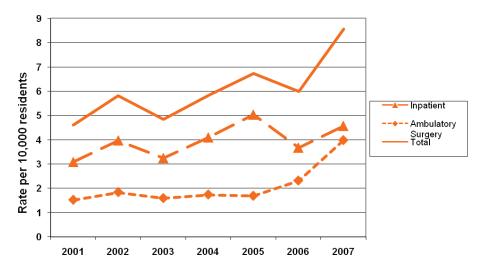**Figure 89. Chronic Digestive Disease Rate Per 10,000 Residents, ARHN Region**

Figure 90. Inpatient Chronic Digestive Disease Rate Per 10,000 Residents
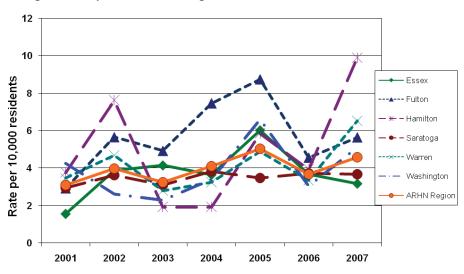

Figure 91. Ambulatory Surgery Chronic Digestive Disease Rate Per 10,000 Residents

Figure 92. Total Chronic Digestive Disease Rate Per 10,000 Residents

Chronic Urinary Disease

Figure 93: Overall hospital utilization rates for Chronic Urinary Disease have increased over the last 7 years to a high of 3.7 per 10,000 residents, although they dipped for a few years in between 2001 and 2007. The overall trend follows the inpatient trend. Ambulatory Surgery rates have remained somewhat stable, fluctuating around .5 per 10,000 residents.

Figure 94: Inpatient utilization rates show very little variation around the regional average, with the exception of Hamilton County, which experienced a spike in utilization in 2006 to 4 per 10,000 residents.

Figure 95: Ambulatory Surgery rates show more fluctuation over the period with every county somewhat higher or lower than the average every year.

Figure 96: Overall, over the past several years, Hamilton, Washington and Warren counties were somewhat higher than the regional average.

Figure 93. Chronic Urinary Disease Rate Per 10,000 Residents, ARHN Region

Figure 94. Inpatient Chronic Urinary Disease Rate Per 10,000 Residents
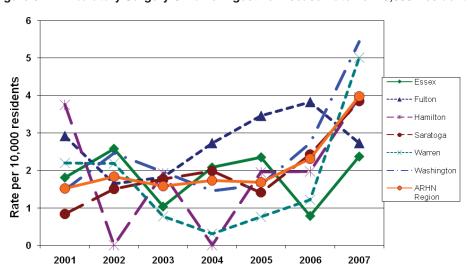

Figure 95. Ambulatory Surgery Chronic Urinary Disease Rate Per 10,000 Residents

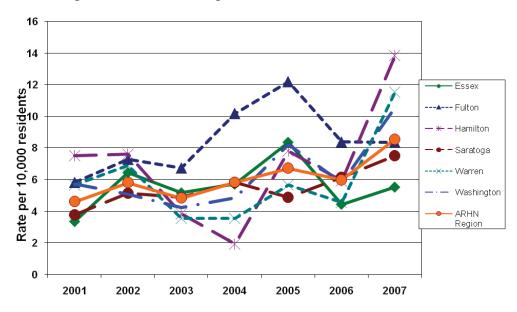**Figure 96. Total Chronic Urinary Disease Rate Per 10,000 Residents**

Chronic Skin Disease

Figure 97: Overall hospital utilization for Chronic Skin Disease remained stable from 2001-2004, then increased and then decreased, for an overall decline in utilization over the past 7 years at around 2.2 per 10,000 residents. Inpatient rates have remained somewhat stable, while ambulatory surgery rates have declined slightly after several years of remaining relatively stable.

Figure 98: Inpatient utilization has been fluctuating around the county averages over the past few years.

Figure 99: Hamilton County has the most variation in outpatient utilization.

Figure 100: The total hospital utilization by county also varies greatly. For the most part, Washington County is somewhat higher than average, with rates fluctuating around 4 per 10,000 residents.
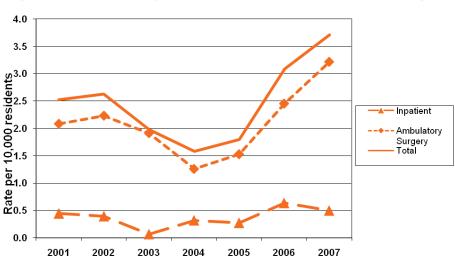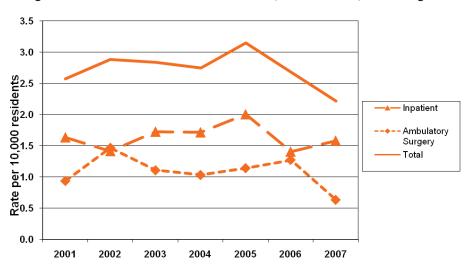
Figure 97. Chronic Skin Disease Rate Per 10,000 Residents, ARHN Region

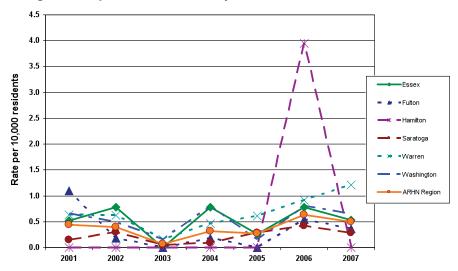**Figure 98. Inpatient Chronic Skin Disease Rate Per 10,000 Residents**

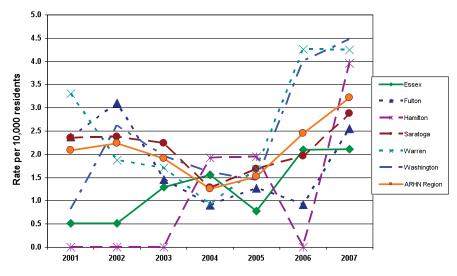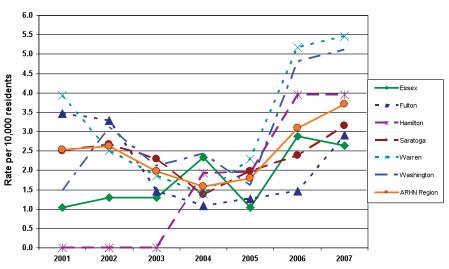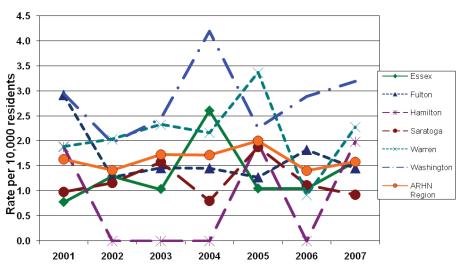**Figure 99.   Ambulatory Surgery Chronic Skin Disease Rate Per 10,000 Residents**
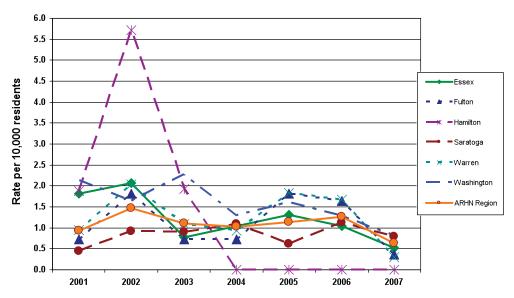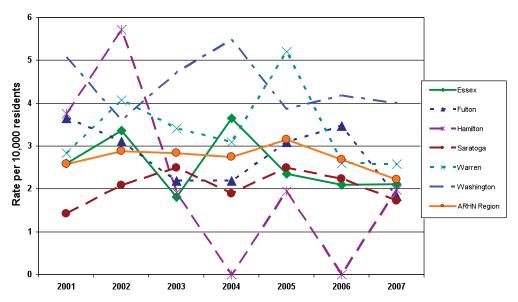
Figure 100. Total Chronic Skin Disease Rate Per 10,000 Residents

Musculoskeletal Disease

Figure 101: Overall hospital utilization rates for Musculoskeletal Disease is increasing in the region from 195 to almost 240 per 10,000 residents, as are ambulatory surgery rates from 130 to 150. Inpatient rates are remaining relatively consistent at around 70 per 10,000 residents.

Figure 102: At the county level, inpatient utilization varies and has been fluctuating among counties. Essex and Saratoga counties have consistently lower than average rates for inpatient utilization while Hamilton, Warren and Fulton counties have higher than average rates.

Figure 103: For ambulatory surgery, Warren and Washington counties have higher than average rates, with Warren's rate reaching a high of 235 per 10,000 residents. Essex, Fulton and Saratoga counties generally have lower than average rates.

Figure 104: In total, Hamilton, Washington and Warren counties have higher than average utilization rates.
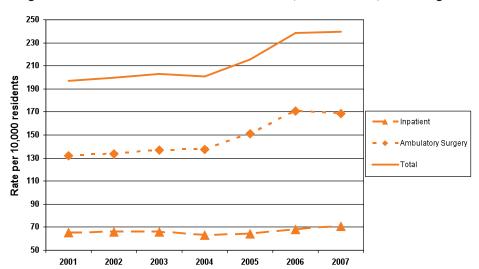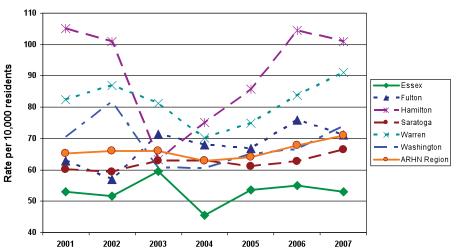
Figure 101. Musculoskeletal Disease Rate Per 10,000 Residents, ARHN Region
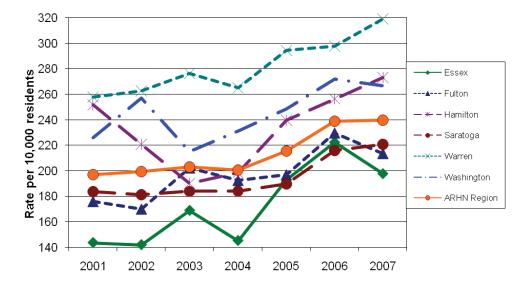
Figure 102. Inpatient Musculoskeletal Disease Rate Per 10,000 Residents

Figure 103. Ambulatory Surgery Musculoskeletal Disease Rate Per 10,000 Residents

Figure 104. Total Musculoskeletal Disease Rate Per 10,000 Residents

Ideas Generated from Focus Groups

During the focus groups ideas related to specific chronic diseases were not brought up or discussed by participants. Focus group feedback centered on broader community health and behaviors, and did not get disease specific. There are no focus group ideas provided under chronic illness as none were generated.

Community Preparedness

State Approved Emergency Preparedness Plans

Table 37: Illustrates that 100% of regional counties as well as the state have emergency preparedness plans.

Table 37. Community Preparedness: State-Approved Emergency Preparedness Plans, All Counties

Community Preparedness	Essex 2004 2005 2006	Fulton 2004 2005 2006	Hamilton[3] 2004 2005 2006	Saratoga 2004 2005 2006	Warren 2004 2005 2006	Washington 2004 2005 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
% of population living within jurisdiction with state-approved emergency preparedness plans[1]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		100.0	100.0	

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Community Preparedness

Figure 105: As reported in the 2004/07 survey, 20% of regional respondents received training in First Aid and/or CPR in the past two years. Hamilton and Essex counties (24%) had slightly higher percentages of respondents receiving the trainings, whereas Fulton County (16%), had fewer than the regional rate.

Figure 105. Percentage of Respondents Received First Aid and/or CPR Training, Past 2 Years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	24%	24%	19%	19%	22%	16%	20%

Emergency Ambulance Service

Figure 106: In the 2004/07 survey, 77% of regional respondents indicated that they were satisfied with emergency ambulance service. These results varied somewhat by county, with Warren and Washington counties reporting a low of 73% and Hamilton County with a high of 89%.

Figure 107: In the 2004/07 survey 16% of regional respondents indicated that someone in their household had received emergency ambulance services in the past 12 months. The data is relatively consistent across counties, with Hamilton reporting a low of 12% and Washington a high of 19%.

Table 38: In the 2004/07 survey respondents were asked what time of day that they had utilized the ambulance. The most frequent response was daytime working hours, 8:00 a.m. – 5:00 p.m. (43%) followed by evening, 5:00 p.m. - midnight (34%).

Table 39: Respondents were also asked to rate their confidence in the ambulance services provided. Essex County respondents reported the highest level of excellent (72%); most other counties were rated around the average of 65%.

Tables 40 and 41: Essex County respondents were more likely than others to rate the professional manner of the personnel as excellent (79%) and that they were receiving the highest level of care (72%).
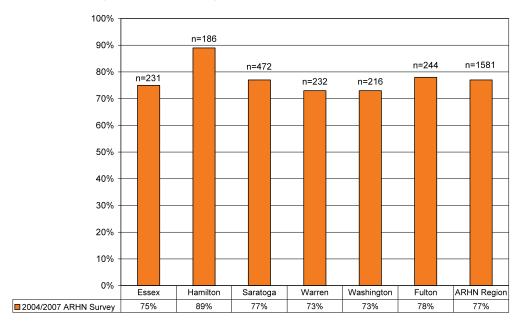
Figure 106.   Percentage of Respondents Satisfied with Ambulance Service

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	75%	89%	77%	73%	73%	78%	77%
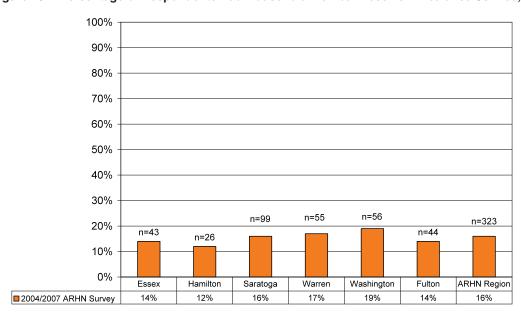
Figure 107. Percentage of Respondents Had Household Member Receive Ambulance Service, Past 12 Months

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	14%	12%	16%	17%	19%	14%	16%

Table 38. Time of Day of Last Ambulance Service, by County

What time of day was your most recent experience with your area's emergency ambulance service?		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
Early morning: 5 AM to 8 AM	Count	6	3	13	10	3	5	40
	%	14.0%	11.5%	13.1%	18.2%	5.4%	11.4%	12.4%
Daytime, working hours: 8 AM to 5 PM [8:01 5:00]	Count	20	15	36	23	21	25	140
	%	46.5%	57.7%	36.4%	41.8%	37.5%	56.8%	43.3%
Evening: 5 PM to Midnight [5:01 12:00]	Count	15	6	34	18	25	13	111
	%	34.9%	23.1%	34.3%	32.7%	44.6%	29.5%	34.4%
Late night, middle of the night: Midnight to 5 AM [12:01 4:59]	Count	2	1	13	4	6	0	26
	%	4.7%	3.8%	13.1%	7.3%	10.7%	.0%	8.0%
Don't Know/Not Sure	Count	0	1	2	0	1	1	5
	%	.0%	3.8%	2.0%	.0%	1.8%	2.3%	1.5%
Refused	Count	0	0	1	0	0	0	1
	%	.0%	.0%	1.0%	.0%	.0%	.0%	.3%
Total	Count	43	26	99	55	56	44	323
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 39. Confidence in Ambulance Service, by County

Your confidence in the services provided?

		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
Excellent	Count	31	16	61	37	35	30	210
	%	72.1%	61.5%	61.6%	67.3%	62.5%	68.2%	65.0%
Good	Count	10	6	30	14	18	11	89
	%	23.3%	23.1%	30.3%	25.5%	32.1%	25.0%	27.6%
Poor	Count	0	0	3	2	1	1	7
	%	.0%	.0%	3.0%	3.6%	1.8%	2.3%	2.2%
N/A	Count	1	3	4	2	1	1	12
	%	2.3%	11.5%	4.0%	3.6%	1.8%	2.3%	3.7%
Refused	Count	1	1	1	0	1	1	5
	%	2.3%	3.8%	1.0%	.0%	1.8%	2.3%	1.5%
Total	Count	43	26	99	55	56	44	323
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 40. Ambulance Personnel Professionalism, by County

Professional manner of the personnel?

		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
Excellent	Count	34	18	65	35	37	29	218
	%	79.1%	69.2%	65.7%	63.6%	66.1%	65.9%	67.5%
Good	Count	8	5	24	17	15	12	81
	%	18.6%	19.2%	24.2%	30.9%	26.8%	27.3%	25.1%
Poor	Count	0	0	3	1	1	1	6
	%	.0%	.0%	3.0%	1.8%	1.8%	2.3%	1.9%
N/A	Count	1	2	6	2	2	1	14
	%	2.3%	7.7%	6.1%	3.6%	3.6%	2.3%	4.3%
Refused	Count	0	1	1	0	1	1	4
	%	.0%	3.8%	1.0%	.0%	1.8%	2.3%	1.2%
Total	Count	43	26	99	55	56	44	323
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 41. Satisfaction with Level of Ambulance Care, by County

You're receiving the highest level of care required?

		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
Excellent	Count	31	15	65	34	36	27	208
	%	72.1%	57.7%	65.7%	61.8%	64.3%	61.4%	64.4%
Good	Count	9	7	21	15	13	14	79
	%	20.9%	26.9%	21.2%	27.3%	23.2%	31.8%	24.5%
Poor	Count	1	1	3	3	1	1	10
	%	2.3%	3.8%	3.0%	5.5%	1.8%	2.3%	3.1%
N/A	Count	1	2	9	2	5	1	20
	%	2.3%	7.7%	9.1%	3.6%	8.9%	2.3%	6.2%
Refused	Count	1	1	1	1	1	1	6
	%	2.3%	3.8%	1.0%	1.8%	1.8%	2.3%	1.9%
Total	Count	43	26	99	55	56	44	323
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Ideas Generated from Focus Groups

Focus group ideas related to community preparedness have been clustered together with ideas related to other priorities and policy change and are included in the Stakeholder Focus Group and Input section of this study.

Asthma

Figure 108: In the 2008 survey 17% of the regional respondents have been told they had asthma, which is equivalent to the state rate. There is some fluctuation among the counties, with Essex reporting the highest rate of 21% and Hamilton with the lowest rate of 13%.

Figure 109: A total of 12% of respondents in the 2008 survey indicated that they currently have asthma, compared to a state rate of 10%. Essex County reports the highest rate of 16%, while Hamilton has the lowest rate at 9%. This is comparable to the results from the 2004/07 survey.
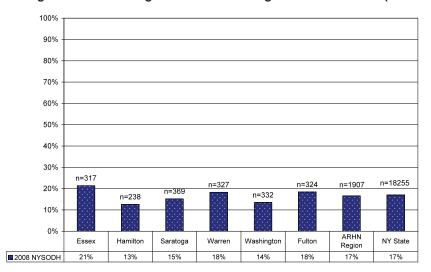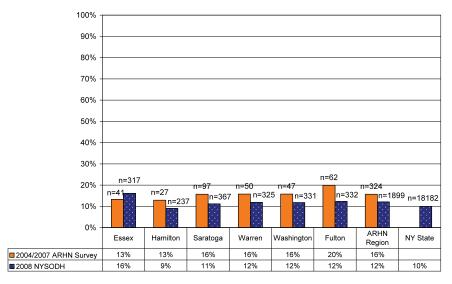
Figure 108. Percentage of Adults Ever Diagnosed with Asthma (Lifetime)

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSODH	21%	13%	15%	18%	14%	18%	17%	17%

Figure 109. Percentage of Adults with Current Asthma

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	13%	13%	16%	16%	16%	20%	16%	
2008 NYSODH	16%	9%	11%	12%	12%	12%	12%	10%

CHA Data Healthy Environment Indicators for Asthma

Table 42: There were 11 CHA data indicators for asthma.

In terms of asthma, the available CHA data indicates that on average the ARHN region has much better rates than Upstate New York, New York State, and the United States.

For the two New York State Department of Health Prevention Agenda priorities at the top of the table, the ARHN average is well within the New York State 2013 Goal for asthma hospitalizations at 12.4 per 10,000 residents, and the region essentially meets the goal for asthma hospitalizations for age 0-17, at 17.4 per 100,000 residents.

Table 42. Healthy Environment: Asthma Incidence, All Counties

Asthma	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Asthma hospitalizations (per 10,000)[1,2]	6.6	7.0	6.6	18.1	19.0	19.6	6.3	5.1	5.2	6.3	5.1	7.4	10.0	11.1	12.3	9.4	0.0	8.8	10.0	9.7	12.4	21.0	16.7	16.6
Asthma hospitalizations age 0-17 (per 10,000)[1,2]	7.1	7.9	7.0	34.0	33.2	32.9	10.7	7.3	3.6	12.0	11.5	11.2	0.0	13.1	12.8	12.3	11.0	11.5	13.2	13.7	17.4	31.5	17.3	22.6
Asthma mortality (per 1,000,000)[2]	26.4	26.4	19.2	26.9	12.3	5.8			0.0			6.4	4.4	4.5	3.7	19.3	10.1	14.9	8.3	8.1	8.6			
Asthma hospitalizations age 0-4 (per 10,000)[2]	17.3	23.4	19.5	93.9	97.3	90.4	30.3	14.9	0.0	35.7	33.8	32.1		35.5	35.5	36.1	32.8	36.1	35.6	39.0	37.8	61.7	25.0	
Asthma hospitalizations age 65+ (per 10,000)[2]	14.3	16.5	17.5	20.4	17.3	18.4	6.3	9.4	15.6	9.5	10.5	9.5	11.3	11.7	13.6	14.7	9.0	10.1	14.1	12.0		30.0	11.0	
Asthma hospitalizations age 5-64 (per 10,000)[2]	4.6	4.5	4.0	11.5	12.8	13.9	4.2	3.4	4.2	4.6	5.0	5.1	0.0	9.3	10.8	6.2	5.9	6.4	7.4	7.1	9.6			7.7
Asthma hospitalizations age 5-14 (per 10,000)		4.5	4.7		15.4	18.7		6.3	6.6		4.9	5.0		5.7	7.3		5.5	5.3	7.9	7.1	10.8	23.4		
Asthma hospitalizations age 15-24 (per 10,000)		1.3	1.4		7.7	7.4		0.0	0.0		3.3	3.4		3.8	3.6		1.4	2.3	3.0	3.6				
Asthma hospitalizations age 25-44 (per 10,000)		2.8	2.1		9.8	11.9		5.8	5.6		3.6	3.9		10.2	10.3		8.4	7.8	6.9	6.3		12.2		
Asthma hospitalizations age 45-64 (per 10,000)		7.7	6.9		17.4	16.9		2.0	3.9		7.5	7.5		12.9	16.2		6.2	7.5	9.8	9.9		21.5		
Asthma hospitalizations (per 10,000)		7.0	6.6		19.0	19.6			5.2			5.2		11.2	12.3			8.8	9.6	8.7		21.0		

NOTES:
☐ County average is "Worse" than the NY Upstate average, or than the NY State average if the Upstate average is not available.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

CHA Data Healthy Environment Indicators for Other Issues in the Home, Work & Social Environment

Table 43: There were seven CHA data indicators for Other Healthy Environment issues.

In terms of healthy environment indicators in the CHA data, other than those for asthma presented above, the ARHN region was generally better than average, with two exceptions – elevated lead levels age 16+, and asbestosis hospitalizations age 15+.

Four counties exceeded the average for elevated lead levels, Fulton, Saratoga, Warren, and Washington, while three exceed the average for asbestosis hospitalizations, Fulton, Saratoga, and Warren.

Lead incidence at age 72 months or less is the only New York State Department of Health Prevention Agenda priority in this group of indicators and four of the counties, Fulton, Saratoga, Warren, and Washington, exceeded the Upstate average on that measure, although the ARHN region weighted average remained below the Upstate average.

Saratoga County exceeded the Upstate average on five of the seven healthy environment measures.

Table 43. Healthy Environment: Other Issues in the Home, Work & Social Environment, All Counties

Other Healthy Environment	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Lead incidence %, age < 72 months, lead level > = 10µg/dl[1]		1.3			4.5			2.1			0.6			1.8			3.0		2.2	1.3	1.7	1.3	0.0	
Work-related hospitalizations age 16+ (per 10,000)[1]	13.1	12.1	11.5	18.2	19.0	20.5	13.1	11.9	13.3	12.9	13.2	20.7	22.5	18.6	18.1	20.1	18.8	18.8	17.2	19.2	19.7	16.0	11.5	
Elevated lead level age 16+, >= 25 µg/dL, (per 100,000)[1]	7.7		5.6			7.8				3.6	4.1	5.9	16.3	8.0	6.8	16.9	8.9	8.6	6.9	6.6	5.8	6.0	0.0	
Assault hospitalizations (per 10,000)[2]	0.6	0.3	0.5	1.4	1.7	2.3	0.0	0.0	0.8	0.0	0.0	0.8	1.1	0.0	1.2	0.8	0.0	0.9	1.1	1.0	2.7			
Homicide mortality (per 100,000)[2]	1.8	1.4	1.3	1.7	1.1			3.6	3.5		3.6	3.5	0.9		1.1	1.2		0.6	2.0	2.1	3.0		3.0	
Fatal work-related injuries age 16+ (per 100,000)		7.5	13.0		0.0			0.0	1.0	3.0	2.9	3.7		0.0			0.0		2.7	2.5	2.7		3.2	
Asbestosis hospitalizations (ICD9 501) age 15+ (per 100,000)	0.0	1.0	1.0	19.5	19.9	29.2	7.3	7.4	7.4	28.8	23.9	23.9	14.9	10.5	17.7	4.7	5.1	10.8	15.0	19.6	17.5			

NOTES:
☐ County average is "Worse" than the NY Upstate average, or than the NY State average if the Upstate average is not available.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
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6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Ideas Generated from Focus Groups

The following list includes information related to Healthy Environment that was generated during the focus groups. Participants were asked to vote for the ideas they felt were top priorities for the region. The ideas were then clustered into themes. The theme of Environmental Issues received 35 collective votes. New pipes, sponsoring a clean up day, and cleaner/greener options were among the suggested ideas.

Please refer to the list below for a complete listing of ideas.

Environmental Issues (35)

- New pipes (5)
- Hold clean up day (4)
- Contact forward thinking companies about cleaner energy possibilities (4)
- Make it mandatory for new business to renovate old buildings - no more new building at least for a while (4)
- Add recycling bins to buildings (3)
- Fines for throwing cigarette butts out the window (3)
- Promote greener lifestyles (2)
- Use greener technology to power public building - free access to generators when the power goes out (2)
- Creation and use of solar and wind power for municipal buildings (2)
- Urge town boards to address problems i.e.. sewage etc. (1)
- Pay to use public bathrooms (1)
- Create environmental awareness (1)
- Canal Awareness Day (1)
- Build greenhouses heated with compost (1)
- Accessible recycling & free garbage disposal - mandate composting (1)

Healthy Mothers, Healthy Babies, Healthy Children

Pregnancy

Figure 110: Only about 1% of the women participating in the 2004/07 survey indicated that they were currently pregnant.

Figure 111: Most women (72%) participating in the 2004/07 survey with children indicated that they had breastfed their last child. The individual county rates can not be reliably reported as the sample sizes were very small.

Figure 112: In the 2004/07 survey, 11% of women reported that they had given birth in the last 5 years.

Figure 113: Although the sample sizes from the survey are very small, almost all (93%) of the women who had given birth in the past 5 years indicated that they had seen a doctor in their first trimester.
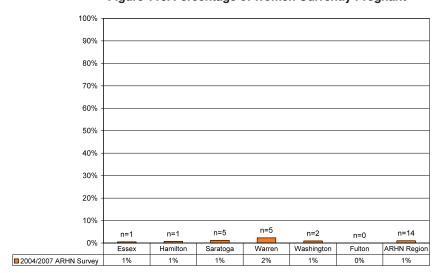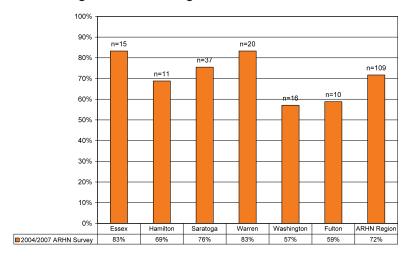
Figure 110. Percentage of Women Currently Pregnant

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	n=1	n=1	n=5	n=5	n=2	n=0	n=14
2004/2007 ARHN Survey	1%	1%	1%	2%	1%	0%	1%

Figure 111. Percentage of Women Who Breastfed Last Child

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	n=15	n=11	n=37	n=20	n=16	n=10	n=109
2004/2007 ARHN Survey	83%	69%	76%	83%	57%	59%	72%
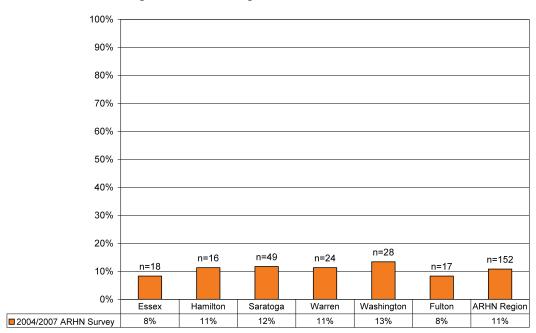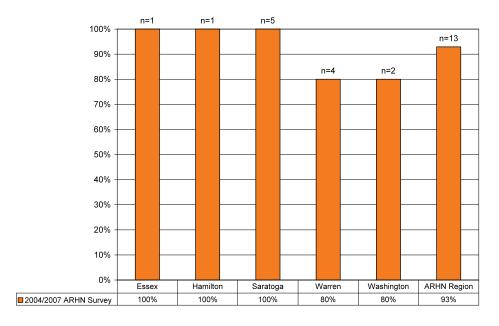
Figure 112. Percentage of Women Who Gave Birth in Past 5 Years

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	n=18	n=16	n=49	n=24	n=28	n=17	n=152
2004/2007 ARHN Survey	8%	11%	12%	11%	13%	8%	11%

Figure 113. Percentage of Women Saw Dr. in 1st Trimester of Pregnancy

	Essex	Hamilton	Saratoga	Warren	Washington	ARHN Region
	n=1	n=1	n=5	n=4	n=2	n=13
2004/2007 ARHN Survey	100%	100%	100%	80%	80%	93%

CHA Data Healthy Mothers, Babies and Children Indicators

Tables 44 – 53: There were 43 CHA indicators for Healthy Mothers, Babies and Children.

There are very few indicators where the weighted average for the ARHN region exceeded the Upstate average. Exceptions included some of the oral health measures and the gastroenteritis hospitalization rate for the 0 - 4 age group. There were 22.7 hospitalizations per 10,000 residents on average in the ARHN region, as compared to a 16.9 hospitalization rate for gastroenteritis in Upstate New York.

There also were two measures of infant mortality where the regional average exceeded the Upstate average. One was fetal death >20 weeks gestation and the other was postneonatal death for infants age 1 month to 1 year. In both cases, Warren and Washington counties exceeded the Upstate average rate

Table 44. Healthy Mothers, Babies, Children: Low Birthweight, Premature Birth, All Counties

Low Birthweight, Premature Birth	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
% Early prenatal care, 1st trimester (per 100 live births)[1,2]	80.8	80.1	78.1	78.5	78.5	79.4	80.0	78.1	77.6	83.7	83.6	83.4	75.5	69.5	62.8	70.1	70.1	68.9	75.0	77.3	77.3	74.9	90.0	83.9
% low birthweight births (<2500 grams)[1,2]	6.6	6.4	6.6	7.0	7.5	7.4	6.6	8.4	4.9	6.2	6.5	6.6	6.6	6.9	7.2	7.9	8.8	8.0	6.8	7.0	7.7	8.3	5.0	8.2
% Births w/late or no prenatal care (per 100 live births)[2]	3.7	3.3	2.5	4.5	4.6	3.1	4.3	3.5	2.0	2.5	2.4	2.6	4.5	3.5	3.8	4.5	3.7	3.4	2.9	2.9	3.8			
% Premature births, < 37 weeks gestation[2]	9.5	10.0	10.1	9.3	10.7	10.8	7.8	10.5	10.9	9.3	10.2	10.9	10.9	10.6	9.8	10.0	10.8	10.7	10.5	10.6	11.7		7.6	
Birthweight, very low, <1.5 Kg (%)[2]	0.9	0.8	0.5	1.0	1.1	1.3	2.5	2.5	0.0	1.2	1.1	1.1	1.3	0.8	0.7	1.5	1.6	1.9	0.9	1.1	1.5		0.9	
% adequate prenatal care (Kotelchuck)	77.4	77.3	77.1	75.3	74.2	74.3	78.4	76.9	76.9	77.4	76.9	77.0	71.0	65.4	60.7	67.3	66.3	65.0	71.8	72.6	68.6		90.0	
% births w/5 minute APGAR <6	14.6	1.1	0.0	38.0	0.5	0.7	32.2	1.7	0.0	17.6	0.8	0.7	35.0	0.3	0.3	30.5	1.1	0.8	0.4	0.6	0.6			
% Premature births < 32 weeks gestation	2.1	1.8	0.0	1.4	1.6	1.7	3.4	2.6	0.0	1.4	1.4	1.5	1.8	1.8	1.6	1.6	1.7	2.1	1.2	1.5	1.9		1.0	
% Premature births 32 to < 37 weeks gestation	7.4	8.2	0.0	7.9	9.2	9.1	4.3	7.9	0.0	7.9	8.8	9.5	9.1	8.9	8.2	8.4	9.1	8.6	5.9	8.2	9.8		6.4	
Birthweight, low singleton births (%)	4.6	4.4	0.0	5.6	5.7	5.6	2.5	4.2	0.0	4.1	4.3	4.3	4.9	4.5	4.9	5.6	6.3	5.7	3.4	4.3	5.5			
Birthweight, very low, singleton births (%)	0.6	0.3	0.0	0.9	0.9	1.1	0.0	0.0	0.0	0.8	0.8	0.7	0.9	0.5	0.5	1.3	1.3	1.2	0.6	0.7	1.0			
Neonatal drug-related discharge rate per 10,000 births	18.8	9.0		34.8	35.9		0.0	0.0		13.8	15.3		15.6	15.5		16.1	36.8		18.8	20.2	54.8			
Newborn drug-related hospitalizations (per 10,000)	26.0	0.0	12.1	37.5	0.0	29.9	0.0	0.0	0.0	12.9	0.0	19.7	15.7	0.0	21.7	18.6	0.0	35.7	19.9	22.7	58.0			
Short Gestation (<37 Weeks) - Percentage Per 100 Live Births	10.0	10.0		9.6	10.7		9.6	10.5		9.8	10.2		11.3	10.6		10.5	10.8		10.5	10.4	11.3			

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events results in unstable rates for Hamilton County.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 45. Healthy Mothers, Babies, Children: Low Birthweight & Premature Birth, ARHN Summary

Low Birthweight, Premature Birth	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
% Early prenatal care 1st trimester (per 100 live births)[1,2]	75.0	77.3	Similar	2	77.3	74.9	90.0	83.9
% low birthweight births (<2500 grams)[1,2]	6.8	7.0	Similar	1	7.7	8.3	5.0	8.2
% Births w/late or no prenatal care (per 100 live births)[2]	2.9	2.9	Better	0	3.8			
% Premature births, < 37 weeks gestation[2]	10.5	10.6	Similar	0	11.7		7.6	
Birthweight, very low <1.5 Kg (%)[2]	0.9	1.1	Better	1	1.5		0.9	
% adequate prenatal care (Kotelchuck)	71.8	72.6	Better	2	68.6		90.0	
% births w/5 minute APGAR <6	0.4	0.6	Similar	3	0.6			
% Premature births < 32 weeks gestation	1.2	1.5	Better	0	1.9		1.0	
% Premature births 32 to < 37 weeks gestation	5.9	8.2	Better	0	9.8		6.4	
Birthweight, low singleton births (%)	3.4	4.3	Better	2	5.5			
Birthweight, very low, singleton births (%)	0.6	0.7	Similar	2	1.0			
Neonatal drug-related discharge rate per 10,000 births	18.8	20.2	Better	0	54.8			
Newborn drug-related hospitalizations (per 10,000)	19.9	22.7	Better	0	58.0			
Short gestation (<37 Weeks) % (per 100 live births)	10.5	10.4	Similar	0	11.3			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 46. Healthy Mothers, Babies, Children: Oral Health, All Counties

Oral Health	Essex 2004	2005	2006	Fulton 2004	2005	2006	Hamilton[3] 2004	2005	2006	Saratoga 2004	2005	2006	Warren 2004	2005	2006	Washington 2004	2005	2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
% 3rd grade children with caries experience (all)[1,2]	60.0			45.1			61.2			42.9			42.2			45.3			49.5	45.1	53.8	54.1	42.0	53.0
% 3rd grade children with untreated caries (all)[2]	47.7				45.1		23.2						18.7			24.9			31.9	31.8	29.6		21.0	
% of 3rd grade children with dental insurance (all)[2]	88.3			84.6			71.3						82.8			69.1			79.2	80.1	75.9			
% of 3rd grade children with dental sealants (all)[2]	51.9				13.8		39.2						16.0			29.6			30.1	25.7	38.1		50.0	
% 3rd grade children reported taking fluoride tablets on a regular basis (all)	88.3				26.8		39.1						53.2			44.2			50.3	49.8	26.9			
% 3rd grade children with at least one dental visit in last year (all)	79.3			86.6			72.8						80.2			71.6			78.1	79.1	77.7			
% 3rd grade children with caries experience, low socio-econ status	59.5						58.6						64.5			64.0			61.7	47.7	65.8		42.0	
% 3rd grade children with dental insurance, low socio-econ status	77.0			76.0			57.3						76.8			70.1			71.4	74.4	79.0			
% 3rd grade children with dental sealants, low socio-econ status	52.4						30.7						29.5			30.2			35.7	34.8	28.9		50.0	
% 3rd grade children with untreated caries, low socio-econ status	47.0						23.2						48.1			38.9			39.3	33.9	41.8		21.0	

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events results in unstable rates for Hamilton County.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 47. Healthy Mothers, Babies, Children: Oral Health, ARHN Summary

Oral Health	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
% 3rd grade children with caries experience (all)[1,2]	49.5	45.1	Better	2	53.8	54.1	42.0	53.0
% 3rd grade children with untreated caries (all)[2]	31.9	31.8	Similar	2	29.6		21.0	
% of 3rd grade children with dental insurance (all)[2]	79.2	80.1	Better	2	75.9			
% of 3rd grade children with dental sealants (all)[2]	30.1	25.7	**Worse**	3	38.1		50.0	
% 3rd grade children reported taking fluoride tablets on a regular basis (all)	50.3	49.8	Better	1	26.9			
% 3rd grade children with at least one dental visit in last year (all)	78.1	79.1	Similar	2	77.7			
% 3rd grade children with caries experience, low socio-econ status	61.7	47.7	Better	0	65.8		42.0	
% 3rd grade children with dental insurance, low socio-econ status	71.4	74.4	**Worse**	**5**	79.0			
% 3rd grade children with dental sealants, low socio-econ status	35.7	34.8	Better	0	28.9		50.0	
% 3rd grade children with untreated caries, low socio-econ status	39.3	33.9	Better	2	41.8		21.0	

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 48. Healthy Mothers, Babies, Children: Infant Mortality, All Counties

Infant Mortality	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Infant mortality (per 1,000 live births)[1,2]	6.6	6.3	5.4	5.2	5.4	4.7	8.3	0.0	0.0	5.2	5.2	4.4	4.2	3.1	4.2	7.0	6.8	8.9	4.6	5.1	5.8	5.8	4.5	6.9
Mortality rate fetal death >20 weeks gest (per 1,000 births)[2]	0.9	2.4	0.0	3.9	3.6	3.5	8.0	2.4	0.0	4.0	5.5	4.3	3.0	8.2	10.0	6.2	9.4	7.8	4.3	5.1	4.7		4.1	
Mortality rate perinatal 28 weeks gest - 7 days of life (per 1,000 births)[2]	0.0	2.4	0.0	6.1	5.4	3.0	0.0	2.4	0.0	5.8	5.8	3.9	3.0	6.7	7.4	4.7	7.3	8.8	3.9	4.6	5.6		4.5	
Mortality rate postneonatal 1 month - 1 year (per 1,000 births)[2]	3.8	3.6	2.7	1.7	1.8	1.8	8.3	0.0	0.0	1.5	1.4	1.1	1.6	2.1	2.7	4.8	3.7	4.2	2.1	2.0	1.7		1.5	
Mortality rate, neonatal <28 days (per 1,000 births)	2.8	2.7	2.7	3.5	3.6	3.0	0.0	0.0	0.0	3.7	3.8	3.2	2.6	1.0	1.6	2.1	3.2	4.7	2.5	3.1	4.1		2.9	
Mortality rate perinatal 20 weeks gest - 28 days of life (per 1,000 births)	3.7	4.9	0.0	7.3	7.2	6.5	0.0	4.9	0.0	7.6	9.3	7.6	5.5	9.2	11.6	8.3	12.5	12.4	6.4	8.0	8.9			
Abortion ratio age 15-19 (per 100 live births)	51.2	48.8		59.9	63.4	55.3	150.0	48.8	0.0	88.3	79.5	87.2	83.0	76.2	77.8	66.8	74.3	72.4	56.9	75.5	82.0			
Abortion Ratio all ages (per 100 live births)	19.3	18.7		23.6	26.2	26.4	15.7	18.7	0.0	19.4	18.7	19.8	30.7	31.5	34.0	25.9	26.0	26.0	20.8	23.3	27.8			

NOTES:

☐ County average is "Worse" than the NY Upstate or NY State average.

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events results in unstable rates for Hamilton County.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives

Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 49. Healthy Mothers, Babies, Children: Infant Mortality, ARHN Summary

Infant Mortality	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Infant mortality (per 1,000 live births)[1,2]	4.6	5.1	Better	1	5.8	5.8	4.5	6.9
Mortality rate fetal death >20 weeks gest (per 1,000 births)[2]	4.3	5.1	Worse	2	4.7		4.1	
Mortality rate perinatal 28 weeks gest - 7 days of life (per 1,000 births)[2]	3.9	4.6	Better	2	5.6		4.5	
Mortality rate postneonatal 1 month - 1 year (per 1,000 births)[2]	2.1	2.0	Similar	**4**	1.7		1.5	
Mortality rate, neonatal <28 days (per 1,000 births)	2.5	3.1	Better	1	4.1		2.9	
Mortality rate perinatal 20 weeks gest - 28 days of life (per 1,000 births)	6.4	8.0	Better	2	8.9			
Abortion ratio age 15-19 (per 100 live births)	56.9	75.5	Better	1	82.0			
Abortion Ratio all ages (per 100 live births)	20.8	23.3	Better	1	27.8			

NOTES:

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives

Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 50. Healthy Mothers, Babies, Children: Childhood Mortality, All Counties

Childhood Mortality	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Childhood mortality age 1-4 years (per 100,000)	48.0	24.7	24.3	14.3	0.0	14.0	0.0	0.0	0.0	17.3	20.7	24.2	13.2	13.0	0.0	13.8	13.4	27.3	15.0	19.5	24.8	21.5	25.0	
Childhood mortality age 5-9 years (per 100,000)	0.0	0.0	34.7	10.2	20.6	21.3	0.0	0.0	0.0	5.0	5.0	7.6	9.2	18.5	9.7	47.1	9.4	0.0	12.2	10.8	11.6	11.7	14.0	
Childhood mortality age 10-14 years (per 100,000)	13.8	13.9	14.4	17.2	34.0	17.3	0.0	0.0	0.0	2.3	0.0	2.3	29.9	14.7	7.7	37.8	23.0	8.0	8.3	6.8	14.1	13.3	17.0	
Childhood mortality age 5-14 years (per 100,000)	7.5	7.6	23.6	14.0	28.0	19.1	62.1	62.5	0.0	3.6	2.4	4.8	20.6	16.4	8.6	41.9	16.9	0.0	9.4	8.0		12.5		
Childhood mortality age 15-19 years (per 100,000)	25.2	37.6	39.7	34.1	33.8	35.9	0.0	0.0	0.0	35.7	23.3	23.8	82.4	58.7	36.9	66.5	56.8	65.6	33.7	34.2		44.5		

NOTES:

☐ County average is "Worse" than the NY Upstate or NY State average.

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events results in unstable rates for Hamilton County.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives

Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 51. Healthy Mothers, Babies, Children: Childhood Mortality, ARHN Summary

Childhood Mortality	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Childhood mortality age 1-4 years (per 100,000)	15.0	19.5	Better	1	24.8	21.5	25.0	
Childhood mortality age 5-9 years (per 100,000)	12.2	10.8	Similar	2	11.6	11.7	14.0	
Childhood mortality age 10-14 years (per 100,000)	8.3	6.8	Better	3	14.1	13.3	17.0	
Childhood mortality age 5-14 years (per 100,000)	9.4	8.0	Better	2		12.5		
Childhood mortality age 15-19 years (per 100,000)	33.7	34.2	Better	1		44.5		

NOTES:

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives

Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 52. Healthy Mothers, Babies, Children: Childhood Disease and Lead Exposure, All Counties

Childhood Disease, Lead Exposure	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
Increase % of 2 year old children who receive recommended vaccines[1]																						82.4	90.0	80.5
% children with at least one lead screening by age 36 months[1]	59.1			84.5			81.6			88.4			81.7			69.8			77.5	81.7	66.4	82.8	96.0	
Otitis media hospitalization rate per 10,000 (0-4 yrs)[2]	0.0	3.3	0.0	2.3	4.5	3.4	15.2	0.0	0.0	1.4	1.9	2.2	0.0	2.1	5.2	2.2	6.5	5.5	5.3	3.2	3.4			
% children underweight (0-4 years, low SES)	6.9		2.3	8.0		5.2	12.5		6.1	8.8		4.4	4.2		3.1	3.6	0.0	1.5	3.8	3.7	4.0			
Children who are anemic age 6 months to 4 years (per 100 children tested)	5.8		5.5	15.5		7.8	10.3		9.8	22.8		16.5	15.0		4.0	18.1		11.0	9.1	11.8	11.5			
Gastroenteritis hospitalizations age 0-4 years (per 10,000)	7.1	19.7	11.7	19.2	21.3	30.5	15.2			18.7	21.6	19.5		24.9	22.0		25.0	35.0	22.3	22.7	16.9			
Otitis media hospitalizations age 0-4 years (per 10,000)		0.0			4.5			0.0			1.9		3.2	2.1			6.5		2.5	2.7	3.3			
Pneumonia hospitalizations age 0-4 years (per 10,000)	21.1	25.6	19.5	75.8	78.3	70.0				26.8	28.5	29.6	28.4	33.2	35.5	23.0	23.9	32.8	37.5	34.7	38.8			

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events results in unstable rates for Hamilton County.
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6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 53. Healthy Mothers, Babies, Children: Childhood Disease & Lead Exposure, ARHN Summary

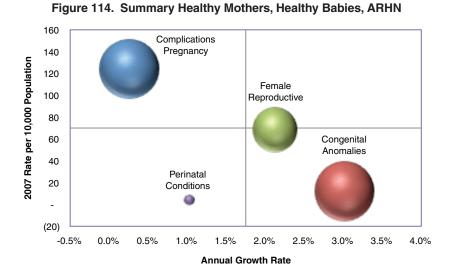| Childhood Disease, Lead Exposure	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Increase % of 2 year old children who receive recommended vaccines[1]						82.4	90.0	80.5
% children with at least one lead screening by age 36 months[1]	77.5	81.7	Better	1	66.4	82.8	96.0	
Otitis media hospitalization rate per 10,000 (0-4 yrs)[2]	5.3	3.2	Similar	3	3.4			
% children underweight (0-4 years, low SES)	3.8	3.7	Similar	2	4.0			
Children who are anemic age 6 months to 4 years (per 100 children tested)	9.1	11.8	Similar	1	11.5			
Gastroenteritis hospitalizations age 0-4 years (per 10,000)	22.3	22.7	**Worse**	3	16.9			
Otitis media hospitalizations age 0-4 years (per 10,000)	2.5	2.7	Better	2	3.3			
Pneumonia hospitalizations age 0-4 years (per 10,000)	37.5	34.7	Better	1	38.8			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Healthy Mothers, Healthy Babies

Figure 114: For hospitalization rates within the Healthy Mothers, Healthy Babies category, Female Reproductive problems are of highest priority. Congenital Anomalies and Complications of Pregnancy are emerging as serious issues due to the large number of patients affected and increasing occurrences. Perinatal Conditions, although also increasing, is of lower priority.

Figure 114. Summary Healthy Mothers, Healthy Babies, ARHN

Pregnancy Complications

Figure 115: From 2001 to 2007, the overall hospital utilization rates related to complications of pregnancy have remained relatively stable, although the inpatient rates are declining slightly and the ambulatory rates are increasing slightly.

Figure 116: Overall, Essex, Hamilton and Washington counties inpatient complication rates are generally lower than the regional average, while Fulton and Saratoga counties rates are somewhat higher. Overall inpatient rates are declining from a high of about 114 per 10,000 residents to 102 per 10,000 residents.

Figure 117 : Ambulatory surgery rates related to complications of pregnancy have remained relatively stable at around 13 per 10,000 residents, although the regional rates spiked in 2007 to 20.
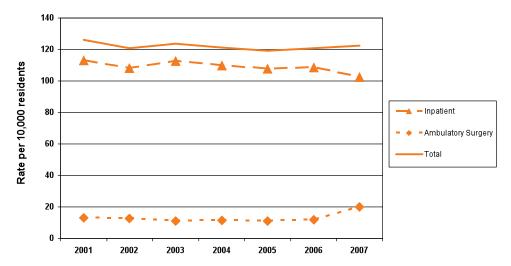
Figure 115. Pregnancy Complication Rate Per 10,000 Residents, ARHN Region

Figure 116. Inpatient Pregnancy Complication Rate Per 10,000 Residents, by County

Figure 117. Ambulatory Surgery Pregnancy Complication Rate Per 10,000 Residents, by County
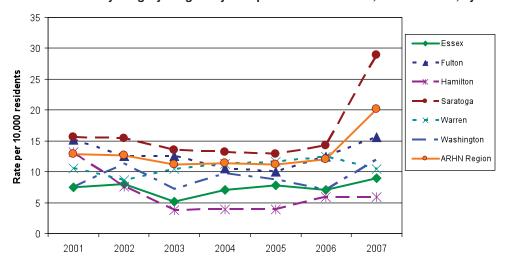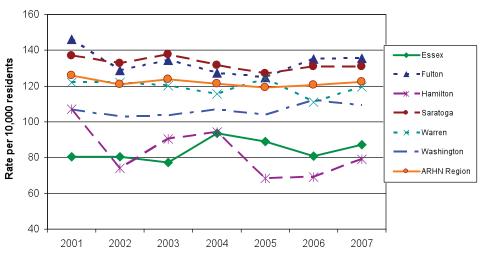
Figure 118. Total Pregnancy Complication Rate Per 10,000 Residents, by County

Congenital Anomalies

Figure 119: Overall the hospital utilization rates related to congenital anomalies have remained relatively consistent, around 11 per 10,000 residents.

Figure 120: Inpatient utilization rates have been fluctuating by county, with Essex demonstrating the lowest rates. Fulton and Washington counties have somewhat higher than average rates.

Figure 121: Regarding ambulatory surgery and in total, Essex County has consistently lower than average utilization.

Figure 122: Total admission rates for Congenital Anomalies have remained relatively consistent over the past six years. Essex and Hamilton counties rates have remained lower than the regional rate. Fulton and Hamilton counties have experienced the most fluctuation with rates over the past six years.
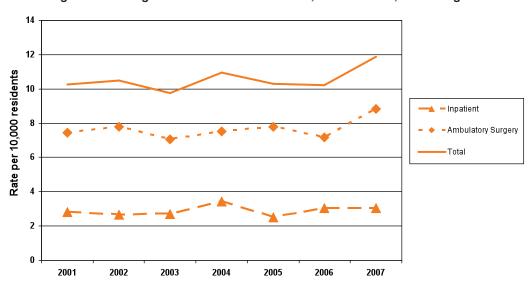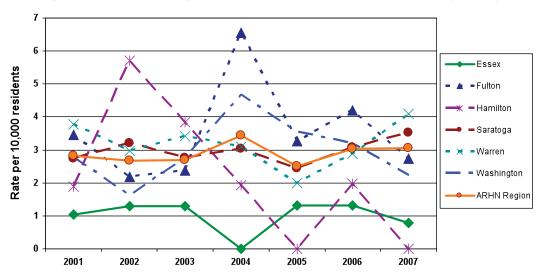
Figure 119. Congenital Anomalies Rate Per 10,000 Residents, ARHN Region

Figure 120. Inpatient Congenital Anomalies Rate Per 10,000 Residents, by County
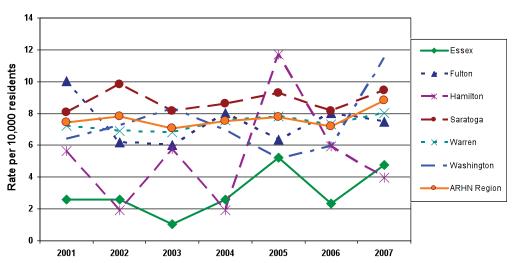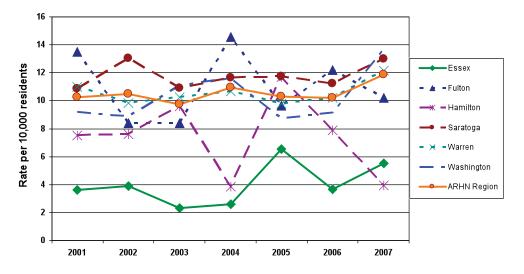
Figure 121. Ambulatory Congenital Anomalies Rate Per 10,000 Residents, by County

Figure 122. Total Congenital Anomalies Rate Per 10,000 Residents, by County

Perinatal Conditions

Figure 123: Hospital Utilization related to perinatal conditions has been increasing in recent years, and then declined again in 2007 to around 3.2 per 10,000 residents.

Figure 124: Fulton County has inpatient utilization rates somewhat higher than average, while Hamilton County has much lower rates, almost zero in most years. Ambulatory surgery utilization for perinatal conditions is almost zero and is not graphed.

Figure 125: Overall admission rates for Perinatal Conditions are relatively low. The ARHN region had rates between three and four per 10,000 residents over the past six years. Hamilton County reported the lowest rates, indicating no admissions for perinatal conditions for five out of the six years. Fulton County reported consistently higher rates than the region.

Figure 123.   Perinatal Conditions Rate Per 10,000 Residents, ARHN Region

Figure 124.   Inpatient Perinatal Conditions Rate Per 10,000 Residents, by County
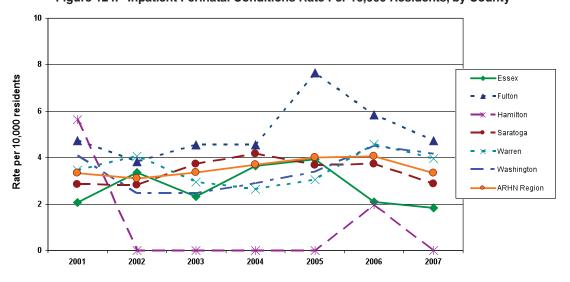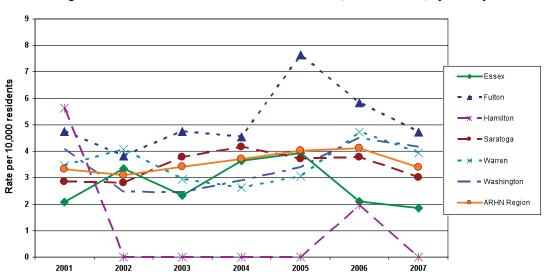

Figure 125.   Total Perinatal Conditions Rate Per 10,000 Residents, by County

Malignant Neoplasms

Figure 126: The total regional hospital rate for Malignant Neoplasms related to female reproductive organs has increased over the past 7 years from 93 per 10,000 residents to 110. Ambulatory surgery rates have followed a similar trend. Inpatient rates have been consistent.

Figure 127: Over the past seven years, inpatient rates in five of the six counties have been consistent. Hamilton County decreased significantly from 91 cases in 2001 to 42 cases in 2007.

Figure 128: Warren County has the highest rates of ambulatory surgery utilization, while Saratoga and Essex counties have lower than average rates.

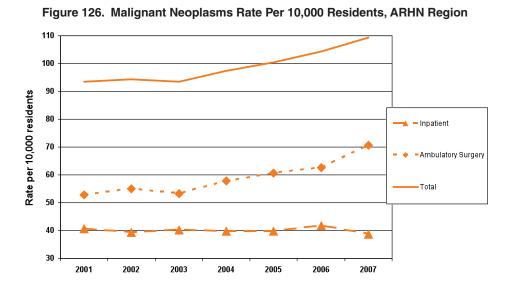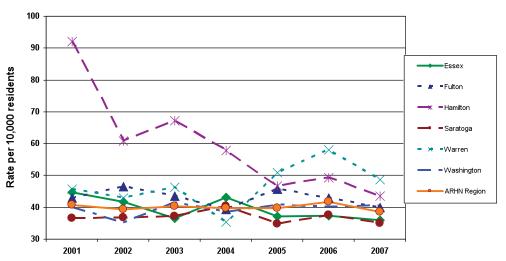Figure 129: Overall, Hamilton and Warren counties have had higher rates of Malignant Neoplasms.

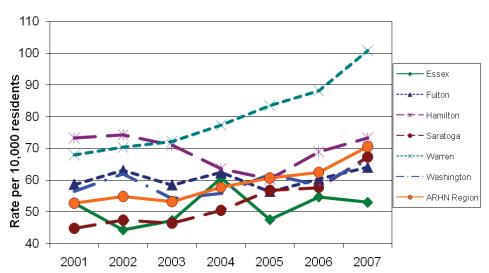**Figure 126. Malignant Neoplasms Rate Per 10,000 Residents, ARHN Region**

Figure 127. Inpatient Malignant Neoplasms Rate Per 10,000 Residents, by County

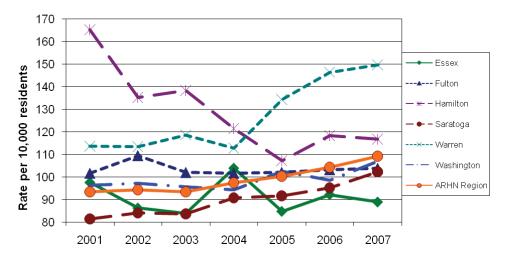**Figure 128.   Ambulatory Surgery Malignant Neoplasms Rate Per 10,000 Residents, by County**

Figure 129. Total Malignant Neoplasms Rate Per 10,000 Residents, by County

Teen Pregnancy

Teenage pregnancy rates were obtained from the 2004-2006 Vital Statistics. Due to confidentiality, rates for Essex and Hamilton Counties were combined. Teenage pregnancy was defined as births to a female between the ages 15-17.

Table 54: Fulton County (2.7%) had the highest percentage of teenage births between 2004-2006, as compared to Essex/Hamilton counties at (0.6%). The regional percentage was 1.4%, which is lower than the state rate at 2.1%.

Table 55: Fulton County also had the highest rate per 1,000 females age 15-19 at 58.3, compared to Essex/Hamilton at 30.6. The regional rate (37.7) was also lower compared to the state rate at 61.3.

Table 54. Teenage Births (Age 15-17) - Percent of Live Births*

	Births (Age 15-17)				Births*	
Region/County	2004	2005	2006	Total	2004-2006	Percent
Essex/Hamilton ~	5	7	1	13	2,029	0.6%
Fulton	12	15	19	46	1,688	2.7%
Saratoga	33	19	21	73	7,101	1.0%
Warren	16	16	12	44	1,884	2.3%
Washington	12	9	13	34	1,918	1.8%
ARHN Region	78	66	66	210	14,620	1.4%
New York State Total	5417	5332	5216	15965	744261	2.1%

Source: 2004-2006 Vital Statistics Data As Of April, 2008
* Total births excludes births with unknown maternal age.
~ Data for Essex and Hamilton counties were combined for the purpose of confidentiality

Table 55. Teenage Pregnancies (Age 15-19) - Rate Per 1,000 Females

	Pregnancies (Age 15-19)				Population	
Region/County	2004	2005	2006	Total	2005	Rate
Essex/Hamilton ~	44	41	40	125	1,362	30.6
Fulton	98	96	112	306	1,751	58.3
Saratoga	256	187	207	650	6,890	31.4
Warren	99	107	102	308	2,200	46.7
Washington	99	106	108	313	2,045	51.0
ARHN Region	596	537	569	1702	14248	37.7
New York State Total	39,236	39,036	40,121	118,393	643,315	61.3

Source: 2004-2006 Vital Statistics Data As Of April, 2008
~ Data for Essex and Hamilton counties were combined for the purpose of confidentiality.
Source: http://www.health.state.ny.us/statistics/chac/birth/tp1519.htm

Ideas Generated From Focus Groups

The following lists include information related to Healthy Mothers, Babies, & Children that were generated during the focus groups. Participants were asked to vote for the ideas they felt were top priorities for the region. The ideas were then clustered into themes.

Ideas relating to Healthy Mothers, Babies, & Children include Parenting/Family Education (36), Youth Services (34), and Youth Brain Drain (18).

Please refer to the list below for a complete listing of ideas.

Parenting/ Family Education (36)

- Establish preconception or prenatal parenting classes (6)

- Teach (3)

- Focus on the "family" (youth/parenting/elderly) (3)

- Community needs to get all forms of information for all ages (3)

- Parents need to take responsibility for children (3)

- Family & parenting education (3)

- Healthy lifestyle parties (2)
- Education - parent training, food choices, budgeting (2)
- Improve support to young families - i.e.: PHN visits monthly (2)
- Empower all residents to invest in family time (2)
- Hold parents responsible (legal, financial) for the actions of their children (2)
- Research (1)
- Be a better father & parent (1)
- Be more honest with your kids (1)
- Make parenting classes mandatory in Jr. and Sr. High school (1)
- More positive guidance in homes through parenting/family education (1)

Youth Services (34)

- Youth centers and programs (12)
- County-wide child care (5)
- Increase funding for youth programs and schools (4)
- Build youth centers for every town equipped w/ comprehensive services for teens (4)
- Listen to Kids (2)
- More work with children (2)
- Encourage the young people by my own experiences (1)
- Teach respect to the youth (1)
- Keep the youth busy so they don't have time to waste (1)
- Improve day care - 1 in each town (1)
- Promote youth programs that reinforce family values & service to others (1)

Youth/ Brain Drain (18)

- Provide more money for kids to go to college or offer a program where the community will pay for school if the student agrees to live and work in the area (8)
- Incentives to bring young people to our community (5)
- Recruit youth to health careers (3)
- Student loan forgiveness for providers (2)

Infectious Disease

Flu Shot

Figure 130: In the 2008 survey, almost half (42%) of regional respondents report having had a flu shot in the past 12 months, which is equal to the state rate. There is some variation by county, with Essex County reporting that 50% of respondents have received flu shots and Fulton County reporting 35%. Hamilton and Washington counties report 38%. These are comparable to the rates from the 2004/07survey.

Figure 131: In the 2008 survey, a very small percentage (2%) of regional and state respondents report having received a flu vaccine nasal spray in the past year. The findings from Essex, Hamilton, Warren, and Washington counties did not meet report criteria from the 2008 New York State Department of Health survey and were therefore not included in their report and the data used to compile this report.

Figure 132: In the 2008 survey, less than half of regional and state respondents (42%) indicated that they had received a flu shot or flu vaccine nasal spray in the past 12 months.

Figure 133: In the 2008 survey, the majority (74%) of adults age 65 and over in the ARHN region report having received a flu shot, which is comparable with the state rate. Fulton County has the lowest rate at 70% and Washington County has the highest rate at 78%.
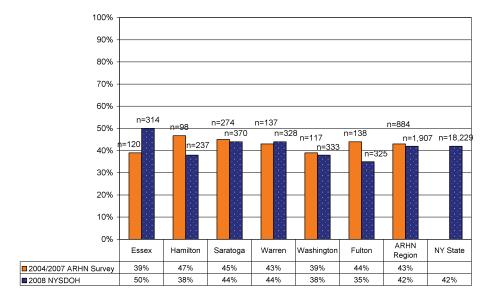
Figure 130. Percentage of Respondents Given Flu Shot within the Past Year

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	39%	47%	45%	43%	39%	44%	43%	
2008 NYSDOH	50%	38%	44%	44%	38%	35%	42%	42%

Figure 131.   Percentage Had Flu Vaccine that was Sprayed in Nose within past 12 months

	Saratoga	Fulton	ARHN Region	NY State
	n=370	n=325	n=695	n=18265
2008 NYSDOH	2%	1%	2%	2%
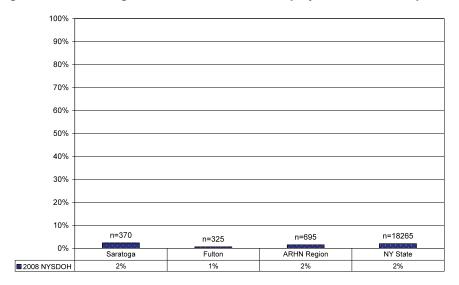
Figure 132. Percentage of Adults Received Flu Shot OR Flu Vaccine Spray in Nose, within past 12 months

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	n=313	n=237	n=370	n=328	n=333	n=325	n=1,906	n=18,221
2008 NYSDOH	50%	38%	46%	44%	38%	35%	42%	42%
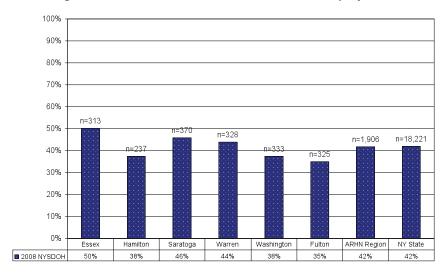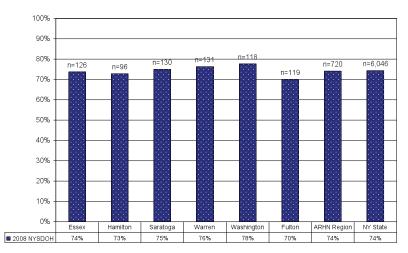
Figure 133. Percentage of Adults age 65 and Older Who Received Flu Shot

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	n=126	n=96	n=130	n=131	n=118	n=119	n=720	n=6,046
2008 NYSDOH	74%	73%	75%	76%	78%	70%	74%	74%

Pneumonia Shot

Figure 134:   In the 2008 survey, almost a third (30%) of regional respondents report having had a pneumonia shot. This is somewhat higher than the state rate of 26%. All regional counties report a higher than state average rate, although Warren County is the lowest at 27% and Saratoga is the highest at 34%.

Figure 135: In the 2008 survey, the majority of respondents (74%) who were adults age 65 and over reported that they had a pneumonia shot. This is higher than the state rate of 64%. Fulton County had the lowest regional county rate at 64%, while Essex, Warren and Washington counties had the highest rates at 77%.
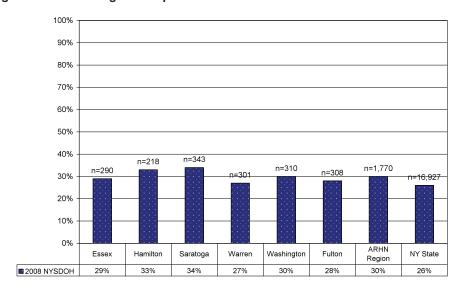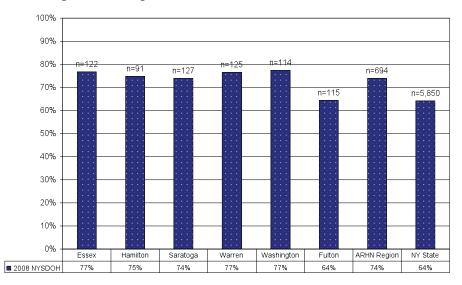
Figure 134. Percentage of Respondents Ever Had Pneumonia Shot or Pneumococcal Vaccine

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	29%	33%	34%	27%	30%	28%	30%	26%

(n=290, n=218, n=343, n=301, n=310, n=308, n=1,770, n=16,927)

Figure 135.   Percentage of Adults age 65 and Older who Received Pneumonia Shot or Pneumococcal Vaccine

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	77%	75%	74%	77%	77%	64%	74%	64%

(n=122, n=91, n=127, n=125, n=114, n=115, n=694, n=5,850)

Sexually Transmitted Diseases

Figure 136: The majority of regional respondents (90%) in the 2008 survey indicated that they believed it was acceptable to discuss sexually transmitted diseases (STDs) in public, which is comparable to the state rate of 89%. Washington County had the lowest percentage agreement with 86%, while Essex and Warren counties had the highest at 92%.

Figure 137: Regional respondents were also likely to feel that STDs were uncommon among their age group (82%), which is slightly higher than the state average (80%).

Figure 138: Most regional adults (67%) also indicate that they have never been or have rarely been asked about their sexual history during a routine check up. This is comparable to the state rate of 66%. Saratoga County had the lowest rate at 61%, whereas Essex County has the highest rate at 74%.
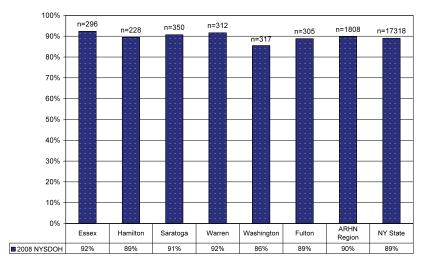
Figure 136.   Percentage of Respondents Approving of Public Discussion of STDs*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	92%	89%	91%	92%	86%	89%	90%	89%

*Adult respondents believed it was at least somewhat acceptable to see or hear discussions about STD risk in public forums in their community.

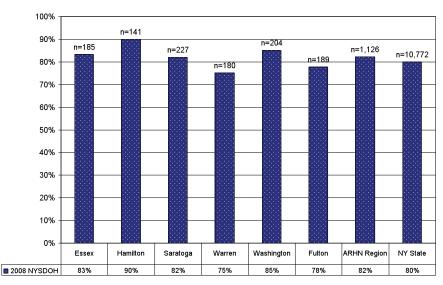**Figure 137.   Percentage of Respondents Believed STDs Uncommon Among Age Group***

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	83%	90%	82%	75%	85%	78%	82%	80%

*Believed hardly any or a few people their age in their community have had an STD such as gonorrhea, chlamydia, herpes or syphilis.

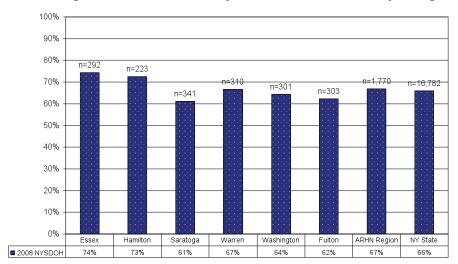**Figure 138.   Percentage of Adults Never or Rarely Asked About Sexual History During Routine Check-up**

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	74%	73%	61%	67%	64%	62%	67%	66%

CHA Data Indicators for Sexually Transmitted Diseases (STDs) and HIV / AIDS

Tables 56–59: There were 16 CHA indicators for Sexually Transmitted Diseases (STDs) and HIV / AIDS. There were no indicators where the ARHN average exceeded the Upstate average and there were very few instances of a county exceeding the Upstate average for a specific indicator in 2006. Exceptions in 2006 were Warren for Early Syphilis and female Chlamydia (age 20-24), Fulton for female Chlamydia (age 15-19), and Essex for Pelvic inflammatory disease (age 15-44).

Table 56.   Infectious Disease: Sexually Transmitted Diseases (STDs), All Counties

STDs	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Gonorrhea (per 100,000)[1,2]	4.3	4.3	5.2	13.9	13.2	13.2	0.0	0.0	0.0	15.4	14.9	13.8	13.4	13.8	14.2	6.5	10.6	11.6	9.7	12.6	66.6	93.4	19.0	120.9
Early Syphilis (per 100,000)[2]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.0	2.0	0.0	0.0	0.0	0.4	0.6	1.9			
female Chlamydia age 15-19 (per 100,000)	9.6	940.8	1022.3	0.0	2449.1	2189.2	0.0	987.7	542.0	0.0	1183.7	1243.3	0.0	1401.6	1454.5	0.0	1359.6	1776.7	1371.3	1440.7	1970.0			
female Chlamydia age 20-24 (per 100,000)	6.0	717.2	756.1	0.0	1923.8	1869.9	0.0	229.9	430.1	0.0	1264.8	1310.2	0.0	1535.8	2046.9	0.0	1126.5	1618.5	1338.6	1475.5	1898.3			
female Chlamydia (per 100,000)	1.3	139.4	134.6	0.0	333.5	301.0	0.0	62.6	50.3	0.0	185.2	190.0	0.0	221.0	248.0	0.0	188.2	235.0	193.2	212.4	338.2			
Gonorrhea age 15-19 (per 100,000)	50.4	37.6	13.2	51.2	50.7	44.9	0.0	0.0	0.0	50.0	39.6	33.3	37.4	44.0	51.6	22.2	35.5	21.9	27.5	33.8	253.0			
male Chlamydia age 15-19 (per 100,000)	0.0	49.3	52.0	0.0	63.7	119.0	0.0	0.0	0.0	0.0	87.3	112.4	0.0	127.3	201.2	0.0	114.9	158.3	107.2	126.5	390.8			
male Chlamydia age 20-24 (per 100,000)	0.2	66.1	47.9	0.0	215.5	256.8	0.0	0.0	0.0	0.0	261.6	321.8	0.0	214.1	307.1	0.0	110.0	132.6	177.7	257.8	640.5			
male Chlamydia (per 100,000)	0.1	14.8	14.9	0.0	33.0	38.9	0.0	0.0	0.0	0.0	0.0	64.7	0.4	48.4	57.4	0.0	112.0	35.9	35.3	51.4	122.8			
Pelvic inflammatory disease age 15-44 (per 10,000)	4.2	6.2	6.2	5.5	5.2	4.0	0.0	0.0	0.0	3.0	4.0	2.1	3.8	4.8	4.0	6.4	4.9	4.1	3.4	3.2	4.4			

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 57. Infectious Disease: Sexually Transmitted Diseases (STDs), ARHN Summary

STDs	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Gonorrhea (per 100,000)[1,2]	9.7	12.6	Better	0	66.6	93.4	19.0	120.9
Early Syphilis (per 100,000)[2]	0.4	0.6	Better	1	1.9			
female Chlamydia age 15-19 (per 100,000)	1371.3	1440.7	Better	1	1970.0			
female Chlamydia age 20-24 (per 100,000)	1338.6	1475.5	Better	2	1898.3			
female Chlamydia (per 100,000)	193.2	212.4	Better	0	338.2			
Gonorrhea age 15-19 (per 100,000)	27.5	33.8	Better	0	253.0			
male Chlamydia age 15-19 (per 100,000)	107.2	126.5	Better	0	390.8			
male Chlamydia age 20-24 (per 100,000)	177.7	257.8	Better	0	640.5			
male Chlamydia (per 100,000)	35.3	51.4	Better	0	122.8			
Pelvic inflammatory disease age 15-44 (per 10,000)	3.4	3.2	Better	1	4.4			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 58. Infectious Disease: HIV / AIDS, All Counties

HIV/AIDS	Essex 2004	2005	2006	Fulton 2004	2005	2006	Hamilton[3] 2004	2005	2006	Saratoga 2004	2005	2006	Warren 2004	2005	2006	Washington 2004	2005	2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
Newly diagnosed HIV case rate (per 100,000)[1]			0.9			3.6			0			3.3			3.1			0	1.8	2.6		24.0	23.0	18.5
HIV/AIDS (per 100,000)[2]	1.7	2.6	2.6	3	6	4.8	0	6.4	6.4	4.8	0	4.3	3.6	3.1	3.6	3.2	2.1	3.2	4.2	4.0	8.2			
HIV/AIDS mortality rate (per 100,000)[2]	0.9	0.9	1.7	0	0.6	0.6	0	0	0	1.4	0	1.1	1	2	1.5	0.5	0.5	0.5	0.9	1.1	2.6			
HIV cases (per 100,000)	0	0	0.9	0	0	3.6	0	0	0	0	0	3.3	0	0	3.1	0	0	0	1.8	2.6	8.2			
HIV exposed newborns (per 1,000 tested)	0	1.4		0	0.7		0	0		0	0		0	0.5		0	1.9		0.8	0.5	1.1			
HIV Positive newborns (per 1,000 tested)	1.5	1.4		1.8	0		0	0		0.3	0.1		0	0		1.3	0		0.3	0.2	1.1			

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 59.   Infectious Disease: HIV / AIDS, ARHN Summary

HIV/AIDS	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Newly diagnosed HIV case rate (per 100,000)[1]	1.8	2.6	Better	0		24.0	23.0	18.5
HIV/AIDS (per 100,000)[2]	4.2	4.0	Better	0	8.2			
HIV/AIDS mortality rate (per 100,000)[2]	0.9	1.1	Better	0	2.6			
HIV cases (per 100,000)	1.8	2.6	Better	0	8.2			
HIV exposed newborns (per 1,000 tested)	0.8	0.5	Better	2	1.1			
HIV Positive newborns (per 1,000 tested)	0.3	0.2	Better	2	1.1			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

CHA Data Indicators for Infectious and Contagious Diseases

Tables 60-63: There were 13 CHA indicators for Infectious and Contagious Diseases. There were four of the indicators where the ARHN average exceeded the Upstate average in 2006 and those included: Pertussis, Pneumoconiosis age 15+, E. Coli, and Hepatitis A. None of those are New York State Department of Health Prevention Agenda priorities.

For Hepatitis A, where four ARHN counties (Essex, Fulton, Saratoga, and Washington) that exceeded the Upstate average in 2006; the ARHN average of 1.5 per 100,000 residents was still well within the New York State 2013 Goal of 4.5.

Table 60. Infectious Disease: TB, Flu, Measles and Other Contagious Diseases, All Counties

Infectious Disease	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
Tuberculosis (per 100,000)[1,2]	2.6	1.7	0	1.8	0.6	0.6	0	0	0	1.1	1.1	1.2	1.5	1.5	1.0	0	0	0	0.5	0.8	2.8	6.8	1.0	4.4
H. Influenza (H1B) (per 100,000)[2]	0	0	0	1.8	1.8	1.2	0	0	0	0.97	0.8	1.1	1.56	1.5	1.5	0.54	0.5	1.1	0.8	1.1	1.3			
Measles incidence (per 100,000)[2]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0				
Pertussis (per 100,000)[2]	63.3	67.7	34.5	12.7	2.4	5.4	0	0	0	15.1	16.5	17.5	6.7	7.7	5.6	16.2	16.5	14.3	12.9	15.0	11.1			
Pneumonia/flu hospitalizations age 65+ (per 10,000)[2]	179.5	187.2	189.0	199.8	209.5	205.2	116.6	147.0	125.2	117.0	118.7	123.0	189.4	179.5	180.7	191.3	190.6	184.0	167.9	156.0	186.4			
Rubella incidence (per 100,000)[2]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0				
Shigella incidence (per 100,000)[2]	0	0	0	0.6	0.6	0.6	0	0	0	0.3	0.3	0.3	0.5	0	0	0.5	0	0	0.2	0.2	3.1			
Pneumoconiosis hospitalizations age 15+ (per 100,000)	5.2	5.1	4.1	19.5	19.9	29.2	14.7	14.8	14.8	29.3	24.5	24.5	16.8	14.2	22.6	11.5	7.1	15.9	18.5	21.7	19.6			

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 61.   Infectious Disease: TB, Flu, Measles and Other Contagious Diseases, ARHN Summary

Infectious Disease	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Tuberculosis (per 100,000)[1,2]	0.5	0.8	Better	0	2.8	6.8	1.0	4.4
H. Influenza (H1B) (per 100,000)[2]	0.8	1.1	Better	1	1.3			
Measles incidence (per 100,000)[2]	0.0	0.0						
Pertussis (per 100,000)[2]	12.9	15.0	**Worse**	3	11.1			
Pneumonia/flu hospitalizations age 65+ (per 10,000)[2]	167.9	156.0	Better	2	186.4			
Rubella incidence (per 100,000)[2]	0.0	0.0						
Shigella incidence (per 100,000)[2]	0.2	0.2	Better	0	3.1			
Pneumoconiosis hospitalizations age 15+ (per 100,000)	18.5	21.7	Similar	3	19.6			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 62. Infectious Disease: E. Coli, Hepatitis, Salmonella and Lyme Disease, All Counties

E. Coli, Hepatitis, Lyme	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
E. Coli incidence (per 100,000)[2]	5.1	2.6	4.3	0.6	0.6	0.6	25.3	0	6.4	0.6	1.1	1.1	1.5	0.5	0.5	3.8	3.2	2.6	2.6	1.5	1.2			
Hepatitis A incidence (per 100,000)[2]	0.9	0	1.7	0.6	0	1.2	0	0	0	1	0	1.7	1.5	0	0.5	0.5	0	2.1	1.2	1.5	1.0		4.5	
Hepatitis B incidence (per 100,000)[2]	0	0	0.9	0	0	0.6	0	0	0	1	0	1.2	0	0	0.5	0	0	0	0.5	0.8	0.8			
Salmonella incidence (per 100,000)[2]	16.2	9.4	7.8	10.3	10.8	9.6	12.6	6.4	0	9.4	9.7	12.6	8.2	7.7	7.6	8.1	9	10	7.9	10.6	12.4			
Lyme disease incidence per 100,000)	4.3	3.4	6	0.6	1.8	1.8	6.3	6.4	6.4	10.8	19.1	30.1	5.2	10.7	16.8	12.4	23.4	50.2	18.6	25.1	42.2		9.7	

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 63. Infectious Disease: E. Coli, Hepatitis, Salmonella and Lyme Disease, ARHN Summary

E. Coli, Hepatitis, Lyme	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
E. Coli incidence (per 100,000)[2]	2.6	1.5	Similar	3	1.2			
Hepatitis A incidence (per 100,000)[2]	1.2	1.5	**Worse**	**4**	1.0		4.5	
Hepatitis B incidence (per 100,000)[2]	0.5	0.8	Similar	1	0.8			
Salmonella incidence (per 100,000)[2]	7.9	10.6	Similar	1	12.4			
Lyme disease incidence per 100,000)	18.6	25.1	Better	0	42.2		9.7	

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Infectious/Parasitic Diseases

Figure 139: The hospital utilization rates for infectious/parasitic diseases has increased in the region over the past seven years to almost 30 per 10,000 residents, driven mostly by inpatient utilization rates that have increased.

Figure 140: Most inpatient utilization county rates fluctuate around the regional average. Fulton County rates, are much higher than all others, trending up from 26 to 35 per 10,000 residents from 2001 to 2007.

Figure 141: Ambulatory surgery utilization rates have remained stable at around 6 per 10,000 residents.

Figure 142: Overall, Fulton County rates are higher than other counties.
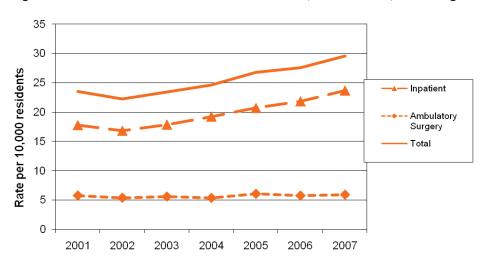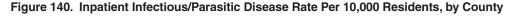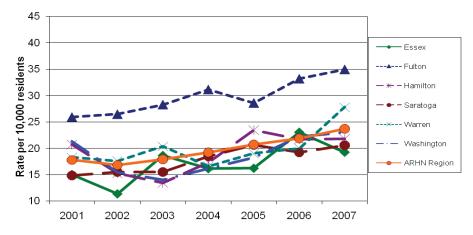
Figure 139. Infectious/ Parasitic Disease Rate Per 10,000 Residents, ARHN Region

Figure 140. Inpatient Infectious/Parasitic Disease Rate Per 10,000 Residents, by County
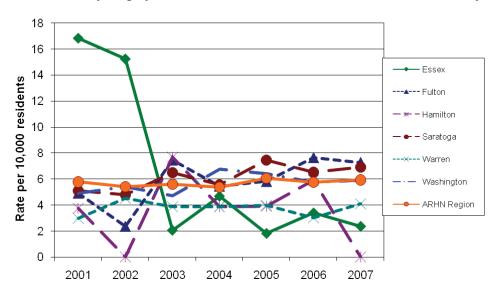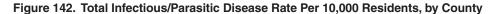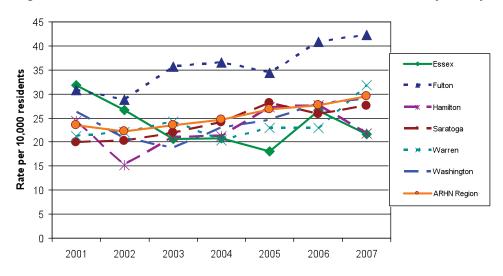
Figure 141. Ambulatory Surgery Infectious/Parasitic Disease Rate Per 10,000 Residents, by County

Figure 142. Total Infectious/Parasitic Disease Rate Per 10,000 Residents, by County

Ideas Generated from Focus Groups

During the focus groups, ideas related to specific infectious diseases were not brought up by participants. Focus group feedback centered on broader community health and behaviors, and did not get disease specific. There are no focus group ideas provided under infectious diseases as none were generated.

Mental Health and Substance Abuse

Mental Health

Figure 143: In the 2004/07 ARHN survey 17% of regional respondents indicated that they felt sad, blue or depressed for two weeks in a row. Individual county rates are relatively similar.

Figure 144: Regionally, 12% of the respondents in the 2004/07 survey reported that they have depression or other mental health problem.

Figure 145: In the 2004/07 survey, 13% of regional respondents indicated that they had sought help from a health professional for stress, depression or emotional problems in the past 12 months. Sample sizes were very small at the county level and therefore county level differences can not be inferred.

Figure 146: In the 2004/07 survey, regional respondents indicated that they delayed getting the mental health care they needed 13% of the time.

Figure 147: In the 2008 Survey, 12% of regional respondents reported having poor mental health 14 or more days within the past month, comparable to the state rate of 10%. Washington County has the lowest regional county rate at 8%, with Warren and Fulton counties having the highest rates at 15%.

Figure 148: In the 2008 survey, looking at either poor physical or mental health, 19% of regional respondents indicated that they had poor physical or mental health 14 or more days within the past month, compared to a state rate of 18%. Washington and Hamilton counties had the lowest regional county rates at 16%, whereas Fulton County had the highest rate at 23%.
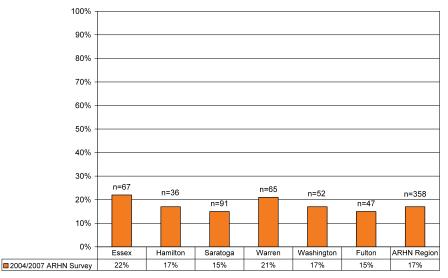
Figure 143. Percentage of Respondents with Depression for 2 Weeks*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	22%	17%	15%	21%	17%	15%	17%
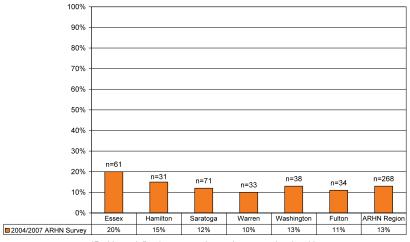
*Defined as respondents that indicated that they felt sad, blue or depressed.

Figure 144.   Percentage of Respondents with Mental Health Problems*

2004/2007 ARHN Survey	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	16%	11%	9%	10%	14%	13%	12%

n=49 (Essex), n=24 (Hamilton), n=58 (Saratoga), n=33 (Warren), n=41 (Washington), n=41 (Fulton), n=246 (ARHN Region)
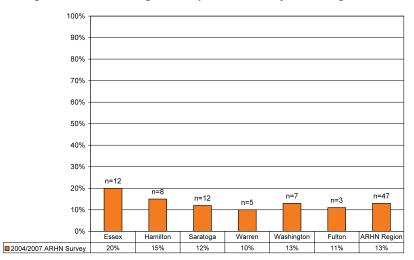
*Defined as respondents indicating they had depression or other mental health problem.

Figure 145.   Percentage of Respondents Sought Help for Mental Health Problems*

2004/2007 ARHN Survey	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	20%	15%	12%	10%	13%	11%	13%

n=61 (Essex), n=31 (Hamilton), n=71 (Saratoga), n=33 (Warren), n=38 (Washington), n=34 (Fulton), n=268 (ARHN Region)

*Problems defined as stress, depression or emotional problems.

Figure 146.   Percentage of Respondents Delayed Getting Mental Health Care

2004/2007 ARHN Survey	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	20%	15%	12%	10%	13%	11%	13%

n=12 (Essex), n=8 (Hamilton), n=12 (Saratoga), n=5 (Warren), n=7 (Washington), n=3 (Fulton), n=47 (ARHN Region)
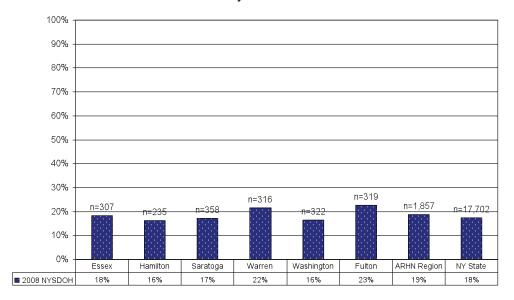
Figure 147.   Percentage of Adults Reporting Poor Mental Health 14 or more Days within Past Month

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	n=307	n=236	n=364	n=325	n=328	n=320	n=1,880	n=17,974
	10%	11%	12%	15%	8%	15%	12%	10%

Figure 148.   Percentage of Adults Reporting Poor Physical or Mental Health 14 or more Days within Past Month

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	n=307	n=235	n=358	n=316	n=322	n=319	n=1,857	n=17,702
	18%	16%	17%	22%	16%	23%	19%	18%

Alcohol Use

Figure 149: The majority of regional respondents (51%) in the 2004/07 survey indicated that they drank alcohol at least once in the last 30 days.

Figure 150: Almost a quarter (23%) of regional respondents in the 2008 survey indicated that they have binge drank in the past month. This is slightly higher than the state average of 20%. Overall, the county averages are consistent with the regional average.

Figure 151: In the 2008 survey 9% of regional respondents indicated that they have participated in heavy drinking in the past month as compared to the state average of 5%. Washington County reports the lowest rate at 6% and Warren County the highest at 11%.

Figure 152: In the 2004/07 survey, respondents were asked if they had driven a vehicle after drinking in the past 12 months. A portion (12%) of regional respondents indicated that they had. Sample sizes were too small at the county level to make note of any differences.
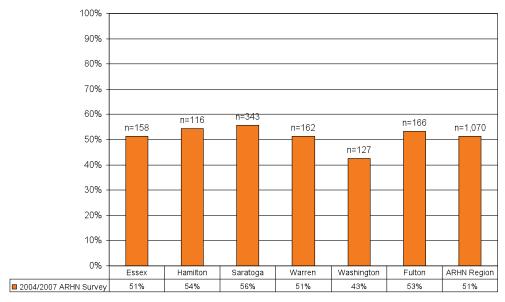
Figure 149.   Percentage of Respondents Who Drank Alcohol in Last Month*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	51%	54%	56%	51%	43%	53%	51%

*Reporting having at least one drink within the past 30 days

Figure 150.   Percentage of Respondents Binge Drinking in Past Month*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	2008 NYSDOH
	n=310	n=234	n=364	n=323	n=330	n=318	n=1788	n=18,069
2008 NYSDOH	25%	22%	20%	23%	22%	23%	23%	20%

*Defined as adult men having five or more drinks or adult women having four or more drinks on one or more occasion within the past month.
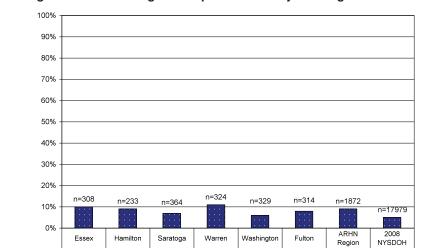
Figure 151.   Percentage of Respondents Heavy Drinking in Past Month*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	2008 NYSDOH
	n=308	n=233	n=364	n=324	n=329	n=314	n=1872	n=17979
2008 NYSDOH	10%	9%	7%	11%	6%	8%	9%	5%

*Defined as adult men averaging more than two alcoholic drinks per day and adult women averaging more than one alcoholic drink per day.
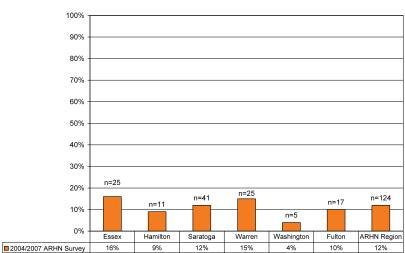
Figure 152.   Percentage of adults who drove after drinking, past 12 months

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	n=25	n=11	n=41	n=25	n=5	n=17	n=124
2004/2007 ARHN Survey	16%	9%	12%	15%	4%	10%	12%

CHA Data Indicators for Mental Health and Substance Abuse

Tables 64 and 65: There were 9 CHA indicators for Mental Health and Substance Abuse.

There were seven out of the nine indicators where the ARHN average exceeded the average for Upstate New York. For three of those indicators, all six counties exceeded the Upstate average. There was another indicator, self-inflicted injury hospitalizations, where five counties exceeded the Upstate average, and there were two indicators where four of the six counties exceeded the Upstate average in 2006.

Suicide mortality rate and Binge Drinking are two of the New York State Department of Health Prevention Agenda priorities where the ARHN average exceeded the Upstate rate. The ARHN suicide mortality rate of 10.3 per 100,000 residents was over twice the New York State 2013 goal of 4.8.

Alcohol-related motor vehicle injuries and deaths was one of the indicators where all six counties exceeded the Upstate average. Cirrhosis mortality was another.

Self inflicted injury hospitalization rates for the 15-19 age group appears to have the highest rate for all of the indicators shown, at 15.5 per 10,000 residents.

There were three counties that exceeded the Upstate average on at least six of the nine indicators, including Essex, Fulton, and Washington counties.

Table 64. Mental Health / Substance Abuse: Suicide and Drug-Related Hospitalizations, All Counties

Mental Health, Substance Abuse	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Suicide mortality rate (per 100,000)[1]	11.9	10.3	**Worse**	**6**	7.1	6.4	4.8	10.9
% Adults that Binge Drink[1,2]	16.6	16.2	Similar	**4**	15.2	34.0	13.4	
Drug-related hospitalizations (per 10,000)[1]	13.2	11.9	Better	0		34.0	26.0	
Alcohol-related motor vehicle injuries and deaths (per 100,000)[2]	10.4	8.3	**Worse**	**6**	5.9			
Cirrhosis mortality (ICD10 K70, K73-K74) (per 100,000)[2]	11.2	9.4	**Worse**	**6**	6.3			
Self-inflicted injury hospitalizations (per 10,000)[2]	6.6	6.8	**Worse**	**4**	5.6			
Suicide mortality rate age 15-19 (per 100,000)[2]	2.3	3.5	Better	2	5.0			
Cirrhosis hospitalizations (ICD9 571) (per 10,000)	2.8	2.7	Similar	3	2.5			
Self-inflicted injury hospitalizations age 15-19 (per 10,000)	17.0	15.5	**Worse**	**5**	11.8			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative reference: Similar is used if the difference is less than 3.0.
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average (or the NYS average if the Upstate value is not available). The number of counties is highlighted in bold if more than half the counties are "worse" than Upstate (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agend

Table 65. Mental Health / Substance Abuse: Suicide and Drug-Related Hospitalizations, All Counties

Mental Health, Substance Abuse	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
Suicide mortality rate (per 100,000)[1]	15.4	14.6	11.5	6.0	8.4	8.0	12.6	6.4	21.7	9.8	10.2	10.7	6.7	7.2	9.2	14.5	11.7	10.3	11.9	10.3	7.1	6.4	4.8	10.9
% Adults that Binge Drink[1,2]	20.4			17.3			17.0			16.3			14.2			14.2			16.6	16.2	15.2	34.0	13.4	
Drug-related hospitalizations (per 10,000)[1]	7.8	8.5	8.9	15.9	17.3	18.6	6.3	8.3	15.1	9.4	10.0	9.9	11.1	13.1	14.6	9.4	11.3	11.8	13.2	11.9		34.0	26.0	
Alcohol-related motor vehicle injuries and deaths (per 100,000)[2]	12.5	12.9	14.5	9.7	10.0	8.7	19.6	14.7	14.7	6.2	6.3	6.5	12.9	11.2	9.5	9.1	8.1	8.6	10.4	8.3	5.9			
Cirrhosis mortality (ICD10 K70, K73-K74) (per 100,000)[2]	12.8	10.3	7.8	8.5	9.0	8.4	6.3	19.1	19.1	8.3	8.9	8.1	9.8	10.7	11.7	7.5	9.6	12.2	11.2	9.4	6.3			
Self-inflicted injury hospitalizations (per 10,000)[2]	8.0	7.5	7.2	5.4	7.2	7.6	1.9	1.9	1.3	5.7	5.6	5.4	9.1	8.7	8.5	6.6	7.5	9.3	6.6	6.8	5.6			
Suicide mortality rate age 15-19 (per 100,000)[2]	12.6	12.5	0.0	0.0	0.0	9.0	0.0	0.0	0.0	2.4	2.3	4.8	0.0	0.0	0.0	0.0	0.0	0.0	2.3	3.5	5.0			
Cirrhosis hospitalizations (ICD9 571) (per 10,000)	2.6	2.8	2.8	4.0	5.0	5.0	2.5	1.3	1.9	1.9	2.2	2.2	2.2	2.1	2.0	1.8	2.8	2.9	2.8	2.7	2.5			
Self-inflicted injury hospitalizations age 15-19 (per 10,000)	21.4	22.5	19.8	13.6	22.0	24.2	11.1	11.4	12.4	13.3	11.2	11.9	15.7	11.7	11.8	9.6	14.9	21.9	17.0	15.5	11.8			

NOTES:

☐ County average is "Worse" than the NY Upstate or NY State average.

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives

Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Mental Health Disease

Figure 153: Overall, inpatient trends for hospital utilization for psychoses are identical, as there is no ambulatory surgery utilization for this condition, with a utilization rate around 41 per 10,000 residents, up from about 38 in 2001.

Figure 154: Warren, Fulton, and Washington counties have reported higher inpatient hospital utilization rates for Pscyhoses than the ARHN Region. Hamilton and Saratoga counties have consistently had inpatient rates lower than that of the region. In the most recent years 2006-2007, five of the six regional counties show a decrease in inpatient hospital utilization rates for Psychoses, Saratoga County being the exception.

Figure 155: Ambulatory surgery rates for psychoses are consistently fewer than 1 per 10,000 residents. Hamilton County reported rates of 7.9 per 10,000 residents in 2007. It should be noted that Hamilton County has a very small population compared to the other counties and the rate was affected when looked at in terms on 10,000 residents.

Figure 156: The total rates for psychoses in the ARHN Region have remained around 40 admissions per 10,000 residents over the 6-year period. The individual counties have reported slight variation over the six years, although Essex has remained consistently higher than the other counties while Hamilton has remained consistently lower.

Figure 157: For the ARHN region, inpatient Other Mental Disease rates per 10,000 residents have fluctuated over the past six years. Inpatient rates held constant around 20 per 10,000 residents from 2001-2004. There is no ambulatory surgery utilization for this condition

Figure 158: Inpatient admission rates for other Mental Health Disease has remained between 15 and 20 per 10,000 residents for the ARHN region over the past six years. Saratoga and Hamilton counties have remained consistently lower than the region, while Warren and Washington counties have remained consistently higher than the region. Overall, Warren County reported the highest inpatient hospital admission rates each year, and Hamilton reported the lowest utilization rates.

Figure 159: Ambulatory Surgery rates for other Mental Health Disease have remained at less than 1 per 10,000 residents over the past six years. The one exception was Hamilton County, reporting almost 2 per 10,000 residents in 2002. It should be noted that Hamilton County's total population is fewer than 10,000 residents which affects the utilization rates when looked at per 10,000 residents.
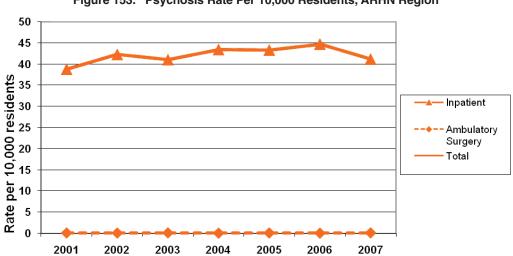
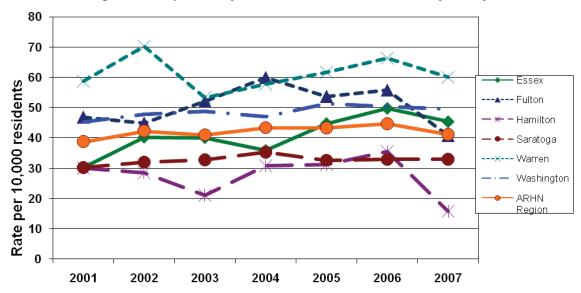**Figure 153.   Psychosis Rate Per 10,000 Residents, ARHN Region**

Figure 154.   Inpatient Psychosis Rate Per 10,000 Residents, by County

Figure 155.   Ambulatory Surgery Psychosis Rate Per 10,000 Residents, by County

Figure 156. Total Psychosis Rate Per 10,000 Residents, by County
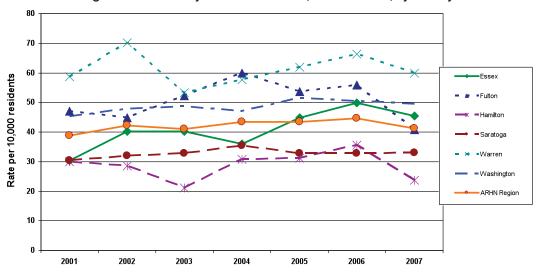
Figure 157. Other Mental Disease Rate Per 10,000 Residents, ARHN Region
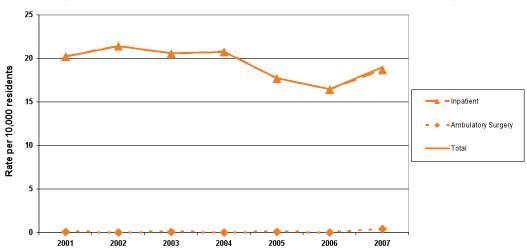
Figure 158.   Inpatient Other Mental Disease Rate Per 10,000 Residents, by County

Figure 159.   Ambulatory Surgery Other Mental Disease Rate Per 10,000 Residents, by County
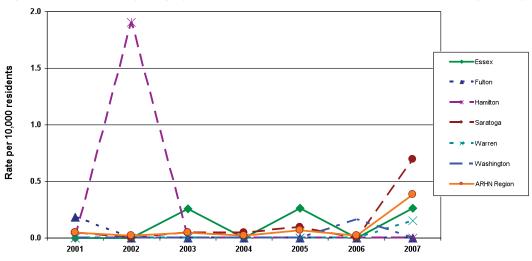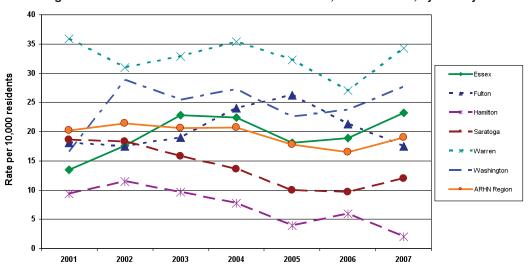
Figure 160. Total Other Mental Disease Rate Per 10,000 Residents, by County

Substance Abuse
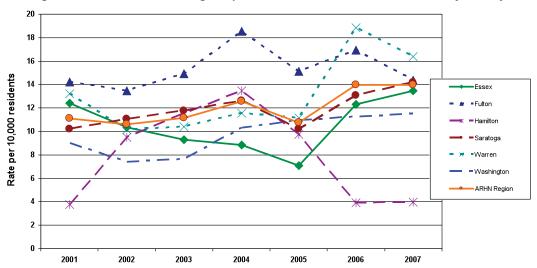
Figure 161: Drug and alcohol related hospitalization is generally inpatient only, and the trend has been increasing in recent years from a low of 11 per 10,000 residents in 2001 to 14 in 2007.

Figure 162: Fulton County has higher than average inpatient utilization rates while Hamilton and Washington counties have somewhat lower rates.

Figure 161. Alcohol/ Drug Hospitilization Rate Per 10,000 Residents, ARHN Region

Figure 162.   Total Alcohol/Drug Hospitilization Rate Per 10,000 Residents, by County

Ideas Generated From Focus Groups

The following lists include information related to Alcohol/Substance Abuse & Mental Health that were generated during the focus groups. Participants were asked to vote for the ideas they felt were top priorities for the region. The ideas were then clustered into themes.

Please refer to the lists below for a complete listing of ideas.

Alcohol/ Substance Abuse (17)

- Pharmacists putting restrictions on how many drugs can be bought at a time (drug overdose) (5)
- Drug testing/ services for people receiving assistance (welfare, unemployment) (3)
- One-on-one advocate for addicted parents & child guides (2)
- Alcohol education - From people who drink & drive kill innocent people (1)
- Drinking and driving classes (1)
- Jail time for smoking when kids are in the car (1)
- Substance abuse rehabilitation (1)
- Show kids the effects of alcohol & drugs on a body using real people (1)
- Community walk-in center for a heroin/ drug addict to go for direction on getting help. All inclusive advice (1)
- Better knowledge of drug use (1)

Mental Health (13)

- Support groups (7)
- Counseling centers for families and youth (2)
- Provide mental health programs (2)
- Formulate mental health programs for all ages (1)
- Increase number of mental health providers (1)

Physical Activity and Nutrition

Nutrition

Figure 163: In the 2008 survey 28% of regional adults report that they eat 5 or more servings of fruits and vegetables a day, compared to a state rate of 27%. The rates are consistent across the counties in the region, although Hamilton County has the lowest rate (23%) and Essex County has the highest rate (33%).

Table 66: In the 2004/07 survey, 36% of regional respondents indicated that they ate 1 to 2 fast food type meals in the last 7 days, although the majority (55%) had not eaten any fast food type meals in the last 7 days.

Figure 163. Percentage of Adults Consuming 5 or More Servings of Fruits and Vegetables per day

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	33%	23%	32%	31%	25%	24%	28%	27%
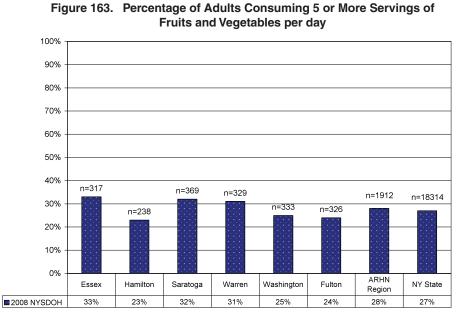
Table 66. Number of Fast Food Meals Consumed in 1 Week, by County

In the past 7 days, how many fast food-type meals did you eat, such as breakfast sausages, hamburgers, french fries, fried chicken, pizza, or other similar foods.

		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
None	Count	178	130	313	182	167	161	1131
	%	57.8%	61.9%	50.8%	57.6%	56.0%	51.6%	54.9%
1 to 2	Count	99	67	244	107	103	128	748
	%	32.1%	31.9%	39.6%	33.9%	34.6%	41.0%	36.3%
3 to 6	Count	26	8	46	20	24	18	142
	%	8.4%	3.8%	7.5%	6.3%	8.1%	5.8%	6.9%
7 or more	Count	3	5	10	6	3	4	31
	%	1.0%	2.4%	1.6%	1.9%	1.0%	1.3%	1.5%
Don't Know/Not Sure	Count	2	0	3	1	0	1	7
	%	.6%	.0%	.5%	.3%	.0%	.3%	.3%
Refused	Count	0	0	0	0	1	0	1
	%	.0%	.0%	.0%	.0%	.3%	.0%	.0%
Total	Count	308	210	616	316	298	312	2060
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Obesity

Figure 164: In the 2004/07 survey, 40% of regional respondents indicated that they were an overweight adult. This finding was somewhat consistent across counties, although Fulton County reported 48% and Warren County reported 37%. In 2008, 36% of regional respondents indicated that they were an overweight adult. Hamilton (47%), Washington (38%), and Fulton (37%) counties reported higher rates of overweight than both the region and state.

Figure 165: In the 2008 survey, 26% of the regional respondents would be classified as obese, as defined by having a body mass index (BMI) of 30 or greater. This is comparable to the state rate of 24%. Warren County has the lowest rate at 21% and Washington County has the highest rate at 32%.

Figure 166: In the 2008 survey, the majority of the regional respondents (62%) would be classified as either overweight or obese, as defined by a BMI of 25 or greater. This is slightly higher than the state rate of 58%. Warren County has the lowest county rate at 53%, whereas Washington and Hamilton counties have the highest regional county rates at 70% and 72% respectively.

Figure 167: In the 2008 survey, about a fourth (23%) of regional respondents indicated that they received advice about their weight from a health professional, compared with the state rate of 28%. Warren and Essex counties have the lowest rate at 20% whereas Fulton and Saratoga counties have the highest rates at 28%.

Figure 168: Of those who received advice about their weight, 88% of regional respondents were advised to lose weight. This is equivalent to the state rate of 88%.

Table 67: In the 2004/07 survey, almost half of regional respondents (49%) indicated that they were trying to lose weight. There were no significant differences in responses across counties.

Figure 169: In the 2008 survey, almost a fifth (18%) of the regional population reports that they spend no time on physical or leisure time activities, compared to a state rate of 23%. Hamilton County has the lowest rate at 11% and Fulton County has the highest rate at 27%.

Figure 170: In the 2008 survey, about a quarter of regional respondents (23%) report having a disability as defined as having activity limitations because of physical, mental, or emotional problems. This is comparable to the state rate at 22%. Washington County has the lowest regional rate at 19%, whereas Fulton County has the highest rate at 28%

Figure 171: In the 2008 survey, a small, but not insignificant percentage of regional adult respondents (7%) indicate that they require some special equipment due to health problems, compared to a state rate of 8%. Hamilton County has the lowest county rate at 5% and Fulton County has the highest rate at 10%.

Figure 172: In the 2008 survey, 25% of regional and state respondents reported having a disability. A disability was defined as having activity limitation due to physical, mental, or emotional problems or having health problems that require use of special equipment. Fulton (29%) and Warren (28%) counties had slightly higher rates compared to the region and the state.

Figure 164. Percentage of Adults Overweight*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2004/2007 ARHN Survey	41%	38%	36%	37%	44%	48%	40%	
2008 NYSDOH	34%	47%	29%	32%	38%	37%	36%	35%

*Defined as having a body mass index (BMI) more than 24.9 but less than 30.0

Figure 165. Percentage of Obesity Among Adults*

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	27%	25%	27%	21%	32%	25%	26%	24%

n=301, n=232, n=360, n=315, n=325, n=309, n=1,842, n=17,537

*Defined as Body Mass Index (BMI) of 30.0 or greater
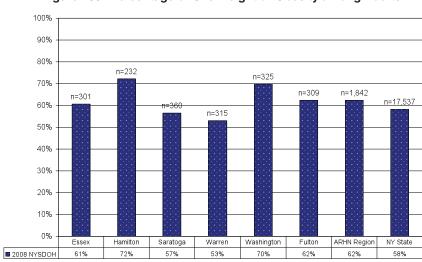
Figure 166. Percentage of Overweight or Obesity among Adults*

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	61%	72%	57%	53%	70%	62%	62%	58%

n=301, n=232, n=360, n=315, n=325, n=309, n=1,842, n=17,537

*Defined as Body Mass Index (BMI) of 25.0 or greater
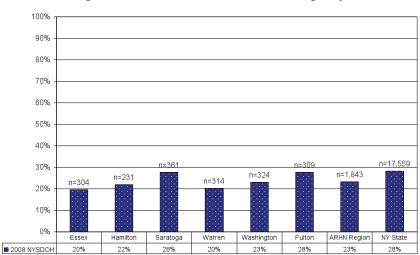
Figure 167. Percentage of Adults Received Advice about Weight by a Health Professional*

2008 NYSDOH	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	20%	22%	28%	20%	23%	28%	23%	28%

n=304, n=231, n=361, n=314, n=324, n=309, n=1,843, n=17,559

*Defined as being advised by a doctor, nurse or other health professional about their weight (lose, gain or maintain).

Figure 168. Percentage of Adults Received Advice to Lose Weight by a Health Professional (of those given advice)

	Essex	Hamilton	Saratoga	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	91%	86%	78%	95%	90%	88%	88%

Table 67. Personal Weight Assessment, by County

In terms of your weight, would you say you are		Essex	Hamilton	Saratoga	Warren	Washington	Fulton	Total
Not concerned about your weight	Count	67	41	109	66	49	61	393
	%	21.8%	19.5%	17.7%	20.9%	16.4%	19.6%	19.1%
Trying to maintain your current weight	Count	95	55	189	93	87	74	593
	%	30.8%	26.2%	30.7%	29.4%	29.2%	23.7%	28.8%
Trying to lose weight	Count	140	106	302	144	152	172	1016
	%	45.5%	50.5%	49.0%	45.6%	51.0%	55.1%	49.3%
Trying to gain weight	Count	6	7	15	10	9	5	52
	%	1.9%	3.3%	2.4%	3.2%	3.0%	1.6%	2.5%
Don't Know/Not Sure	Count	0	1	1	2	1	0	5
	%	.0%	.5%	.2%	.6%	.3%	.0%	.2%
Refused	Count	0	0	0	1	0	0	1
	%	.0%	.0%	.0%	.3%	.0%	.0%	.0%
Total	Count	308	210	616	316	298	312	2060
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 169. Percentage of Adults with No Leisure-Time Physical Activity

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	18%	11%	15%	15%	21%	27%	18%	23%
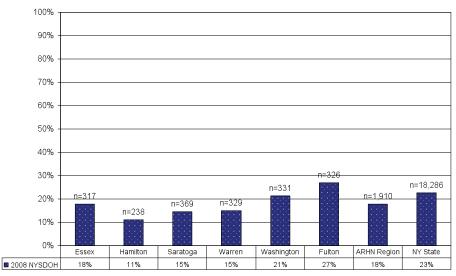
Figure 170. Percentage of Adults with Activity Limitations because of Physical, Mental, or Emotional Problems

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	n=313	n=235	n=368	n=328	n=331	n=325	n=1,900	n=18,198
2008 NYSDOH	22%	24%	22%	25%	19%	28%	23%	22%
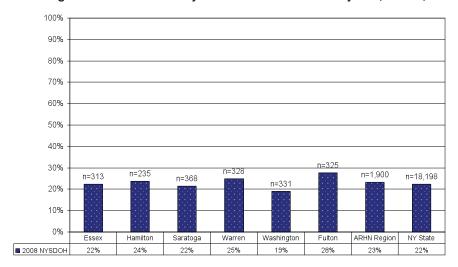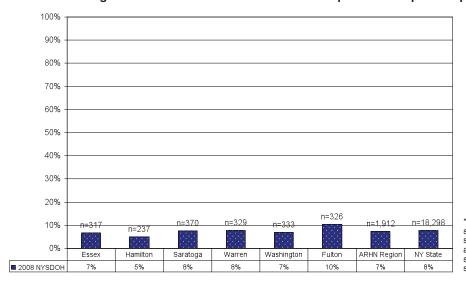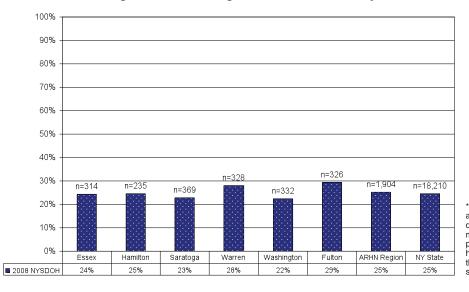
Figure 171. Percentage of Adults with Health Problems that Require use of Special Equipment*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	n=317	n=237	n=370	n=329	n=333	n=326	n=1,912	n=18,298
2008 NYSDOH	7%	5%	8%	8%	7%	10%	7%	8%

*Defined as use of special equipment such as a cane, a wheelchair, a special bed, or a special telephone.

Figure 172. Percentage of Adults with Disability*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
	n=314	n=235	n=369	n=328	n=332	n=326	n=1,904	n=18,210
2008 NYSDOH	24%	25%	23%	28%	22%	29%	25%	25%

*Defined as having activity limitations due to physical, mental, or emotional problems or having health problems that require use of special equipment

CHA Data Indicators for Physical Activity and Nutrition

Tables 68 & 69: There are very few CHA Indicators for Physical Activity and Nutrition. Most indicators for this category are BRFSS or survey data measures. Essex, Hamilton, and Washington counties have higher percentages of obese children age 2-4 years than the region and state. All of the counties with the exception of Hamilton have lower rates of WIC breastfeeding mothers at six months than the region or state.

Table 68. Physical Activity / Nutrition: Obesity, All Counties

Obesity	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
% of obese children, 2-4 years (WIC)[1,2]	12.6	15.4	16.0	12.0	11.2	11.2	26.2	16.8	16.8	14.2	13.4	13.5	14.5	14.9	14.7	14.9	16.8	17.7	15.0	14.2	15.1	15.2	11.6	14.8
% of obese children, grade K[1]																							5.0	
% of obese children, grade 2[1]																							5.0	
% of obese children, grade 4[1]																							5.0	
% of obese children, grade 7[1]																							5.0	
% of obese children, grade 10[1]																							5.0	
% of adults who are obese (BMI > 30)[1,2]			21.7			22.9			22.3			20.9			20.7			20.7	21.5	21.2		22.9	15.0	25.1
% of WIC mothers breastfeeding at 6 months[1]			24.0			12.5						18.9			19.6			18.5	18.7	18.6		38.6	50.0	24.3

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 69. Physical Activity / Nutrition: Obesity, ARHN Summary

Obesity	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
% of obese children, 2-4 years (WIC)[1,2]	15.0	14.2	Similar	3	15.1	15.2	11.6	14.8
% of obese children, grade K[1]							5.0	
% of obese children, grade 2[1]							5.0	
% of obese children, grade 4[1]							5.0	
% of obese children, grade 7[1]							5.0	
% of obese children, grade 10[1]							5.0	
% of adults who are obese (BMI > 30)[1,2]	21.5	21.2	Similar	0		22.9	15.0	25.1
% of WIC mothers breastfeeding at 6 months[1]	18.7	18.6	**Worse**	5		38.6	50.0	24.3

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Ideas Generated From Focus Groups

The following lists include information related to Physical Activity/Nutrition that were generated during the focus groups and involved recommendations for school districts to develop programs. Top themes were also related to promoting wellness and prevention, as well as food and eating habits.

Participants were asked to vote for the ideas they felt were top priorities for the region. The ideas were then clustered into themes.

Please refer to the lists below for a complete listing of ideas.

School Districts (171)

- More funding for school teams, equipment, and games (28)
- Students should receive privileges for doing well (15)
- We should have gym class almost every day so that students are healthier (11)
- More parking spaces for students at school (9)
- Improve sports fields (7)
- Utilize schools in future as community resources (7)
- Hold a schoolwide assembly w/ personal accounts of consequences of drugs and alcohol (7)
- Have Planned Parenthood come in to every school to teach about sexual health (5)
- To establish school-based clinics to assist teens with their needs/ concerns including sexuality/ STDs/ birth control, etc. (5)
- If you do a school sport, you shouldn't have to take gym (4)
- Set up programs like Big Brothers/ Big Sisters in schools and make them more available. (4)
- Develop education programs for the school district to influence healthy lifestyles (4)
- Remove junk food from schools (4)
- Implement farm-to-school for school lunch programs (3)
- Parent/teacher conferences could include healthcare providers, mental health & dietician, etc. (3)
- Assist schools with fully funded exercise equipment (3)
- Mandatory nutrition classes in public schools (3)
- Only provide healthy food choices in schools (3)
- Teach civics again in schools (3)
- Increase after school programs (3)
- Open school buildings for physical activity use (2)
- Increase education of "Service to Community" courses/ clubs/ activities in schools (2)
- Add badminton league to schools, boys, girls, coed. (2)
- Have more counseling services through schools (2)
- Promote the agricultural products being produced in the community throughout schools, by assemblies and posters (2)
- Support free, creative thinking students (2)
- Get State Ed. Dept. to broaden horizon of learning (2)
- Create school gardens and incorporate into curriculum and lunch programs (2)

- Provide help to school cafeteria employees to make healthy meals (2)
- Have a competition between the schools for the best gardens, etc. (2)
- Consolidate schools & resources (2)
- Reform the educational system (increase options & vocational training - change the school year & day) (2)
- School-based/ sponsored summer enrichment programs utilizing local resources (lakes, trails, etc.) (2)
- Provide healthy food choices in school vending machines (2)
- Implement healthy lifestyle behavior education information campaign for parents through school (1)
- Get more equipment for schools to get kids involved in life (1)
- Increase teacher wage and stricter guidelines (1)
- Assess viability of clinics in schools (1)
- Have the schools have seminars about the importance of good nutrition and exercise - guest speakers (1)
- Teach label reading to elementary children through "Nutrition Detectives" (1)
- Enlist education community in the effort to improve community health (1)
- Promote the educational and assistance services that are available (1)
- More healthy actions in schools (1)
- School districts - more communication (1)
- School counselors help high school kids select those career choices that are needed for healthy communities (1)
- More school social workers/ available school nurse (1)

Promote Prevention & Wellness (76)

- Promote health and wellness as a priority at all levels- environmental/ group/ individual (12)
- Lobby for fitness center (11)
- Teach awareness (9)
- Encourage Essex County Government Center to provide space for exercise & fitness area, and to also provide reduction in insurance costs for participating in an exercise program (6)
- Create a culture of prevention (5)
- Provide public health office/ clinic in CNA Building (breastfeeding, prenatal info., etc) (5)
- Community educator (3)
- Make people love abstinence (3)
- Health care needs to focus on making environmental changes to address physical activity, nutrition, tobacco (3)
- Establish health/ wellness centers in each community (3)
- Develop "Healthy Living" education over the life cycle (2)
- Health programs (2)
- Give families access to free non-food items: toilet paper, diapers, shampoo, conditioner etc. (2)
- Establish large scale wellness focused media campaigns (1)
- Leaders to be role models for health (1)
- Go door-to-door (1)
- Educate public about the effect mental illness has on the individuals, the family and the community (1)
- Provide incentives and discounts to those who choose to live a healthy lifestyle (1)

- Streamline flouride acceptance by insurance and Flex spending plans, less dental costs (1)
- Mandatory "Wellness Fairs" to promote education of wellness through funding (ex. state funding only given if you have 2 Wellness Fairs) (1)
- Pay for free flu shots = less lost work time and less healthcare costs (1)
- Get individuals interested in living healthy lifestyles (1)
- Organize coaching for living a sustainable life (1)

Food/ Eating Habits (50)

- Improve school food (9)
- Replace some soda machines with healthier choice machines with water and juice options (8)
- Food pantry (7)
- Better food choices - community gardens, farmers market, health food store that would also work on consignment or membership (7)
- Organize community cooking classes in different locations (3)
- Give out food to the hungry (2)
- Open more healthy restaurants such as Four Seasons (2)
- Foodstamps pay for healthy food only (2)
- Change fast food chains to healthy foods (2)
- Bring food stores to rural areas (1)
- Create guidelines for healthy options at local restaurants- they highlight these options on their own menus (1)
- Encouraging healthy living - nutrition classes (1)
- Healthy foods available and affordable - no price gouging at the local markets (1)
- Use more organic food sources by planting your own fruits & vegetables (1)
- Co-ops to provide adequate and affordable nutrition for the community (1)
- Funding and tax-breaks for local farmers to produce for community (1)
- For each town in Warren & Washington county make a "Healthy Food Pantry"(1)

Walkability Paths/ Bike/ Walk (26)

- Create safer sidewalks (6)
- Build more bike/ walking paths (5)
- Create biking/ walking groups (3)
- Have walkathons or bike-a-thons on our Rail Trail & get kids involved (3)
- Safe routes to walk/ ride to school utilizing walking bus routes for rural areas pooling parent volunteers as coordinators (3)
- Encourage communities to build up/ maintain green spaces for activity (2)
- Develop a bike/walking trail between Chestertown and Brant Lake (1)
- Maintain all the outdoor and indoor activities to promote the health and well-being of all (1)
- Raise awareness in the community for the need for bike paths and sidewalks by getting people together to let the town notice. (1)
- Create a volunteer group to build walking trails - i.e.: Army Corp of Engineers (1)

Employer Programs/Workplace Health (19)

- Incentive based employee wellness (5)
- Mandate state-wide worksite wellness programs, services, and education (4)
- Develop more training programs for unemployed (3)
- Lower the job age while keeping rules to protect the health of minors. (2)
- Work less, Let full time employment = <40 hours (1)
- Create policy/ environment changes to up lactation in the work place (1)
- Develop worksite programs that support volunteerism (1)
- Create employee/ employer "rewards" programs for healthy living (1)
- Increase maternity leave to promote strong bonds - 1 year of paid benefits (1)

Recreational Opportunities (13)

- Create more sport events for the whole town (5)
- We need a functioning community center to service all portions of the population (3)
- More available sport or skate, roller blade, skateboard areas (2)
- Create a year round dog park in Glens Falls and Queensbury (1)
- Public access to land & recreation for boaters (1)
- Provide exercise opportunities for all income levels (1)

Farmers Market (7)

- Closed-in farmer's market building in Elizabethtown for year-round facility; place one in each community; encourage small farmers and specialty foods instead of large scale (4)
- Create farmer's market subsidized by municipal funds to make sure fresh produce is affordable (2)
- Have a farmer's market warehouse area open more frequently - utilize Amish culture to help (1)

Community Gardens (4)

- Create community gardens in every ward of the city (3)
- City designated (at least) one community garden site per city ward (1)

Tobacco Use

Tobacco Use

Figure 173: In the 2004/07 survey, a little over half of the regional respondents (53%) indicated that they had smoked at least 100 cigarettes in their lifetime, with data that was consistent across counties.

Figure 174: In the 2008 survey respondents were asked if they smoked everyday, defined as having smoked at least 100 cigarettes in their lifetime and are currently smoking everyday. About one in five (22%) regional respondents reported smoking everyday, which was higher than the 12% reported at the state level. Fulton (22%) and Essex (21%) counties had the highest prevalence of adults indicating they smoke everyday compared to Hamilton (15%) and Saratoga (14%) counties with the lowest prevalence.

Figure 175: The 2008 survey looked at adults who were currently smoking defined as having smoked at least 100 cigarettes in their lifetime and currently smoking everyday or some days. Again, 22% of regional respondents indicated they currently smoke, which is slightly higher than the state rate of 17%. Both the regional and state rates were higher than the Healthy People 2010 goal of 12%. Fulton (27%) and Essex (24%) counties had the highest rates, compared to Hamilton and Saratoga counties (19%).
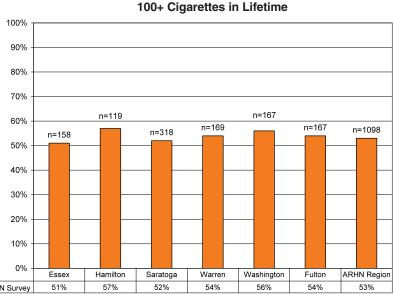
Figure 173. Percentage of Respondents Have Smoked 100+ Cigarettes in Lifetime

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	51%	57%	52%	54%	56%	54%	53%

(n=158, n=119, n=318, n=169, n=167, n=167, n=1098)

Figure 174. Percentage of Adults Smoking Everyday*

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	21%	15%	14%	17%	17%	22%	22%	12%

(n=317, n=237, n=369, n=325, n=333, n=324, n=1905, n=18,217)

*Every day smoking defined as adults who have smoked at least 100 cigarettes in their lifetime and are currently smoking everyday
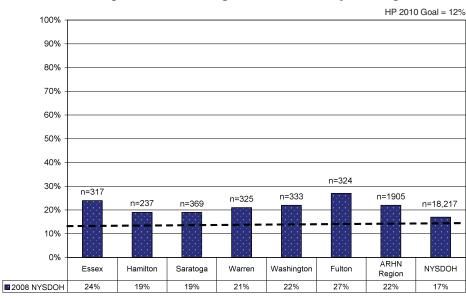
Figure 175. Percentage of Adults Currently Smoking*

HP 2010 Goal = 12%

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NYSDOH
■ 2008 NYSDOH	24%	19%	19%	21%	22%	27%	22%	17%

Defined as smoking at least 100 cigarettes in lifetime and currently smoking everyday or some days.

Quitting Smoking

Figure 176: In the 2004/07 survey, respondents were asked if they had ever used a nicotine patch to quit smoking. Almost a third (31%) indicated that they had. County comparisons are not significantly different because of small n-sizes.

Figures 177 – 184:   Outlines other strategies used to quit smoking. For the ARHN region, they include nicotine gum (16%), Zyban (12%), hypnosis (8%), telephone quit line (2%), internet quit website (4%), doctor recommendation (33%) and group program (6%). A total of 249 people (82%) indicated that they quit smoking with no assistance.

Figure 185: About a third of current smokers (33%) indicated that they have quit for a day or longer when trying to quit smoking completely.
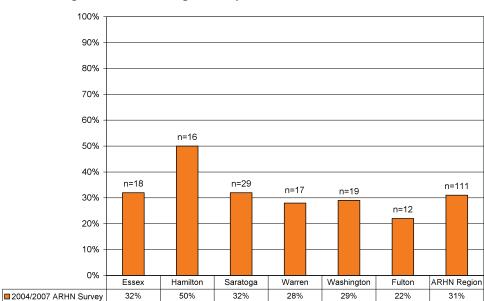
Figure 176. Percentage of Respondents Used Nicotine Patch to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
■ 2004/2007 ARHN Survey	32%	50%	32%	28%	29%	22%	31%

Figure 177.   Percentage of Respondents Used Gum to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	12%	28%	19%	12%	15%	11%	16%

(bar labels: Essex n=7, Hamilton n=9, Saratoga n=17, Warren n=7, Washington n=10, Fulton n=6, ARHN Region n=56)

Figure 178.   Percentage of Respondents Used Zyban to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	16%	25%	10%	12%	14%	4%	12%

(bar labels: Essex n=9, Hamilton n=8, Saratoga n=9, Warren n=7, Washington n=9, Fulton n=2, ARHN Region n=44)
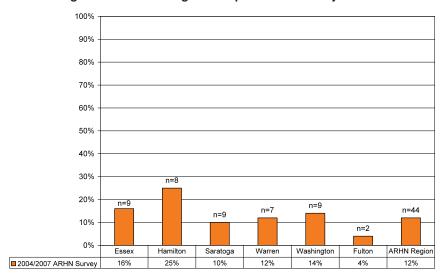
Figure 179.   Percentage of Respondents Used Hypnosis to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	0%	13%	8%	12%	8%	7%	8%

(bar labels: Essex n=0, Hamilton n=4, Saratoga n=7, Warren n=7, Washington n=5, Fulton n=4, ARHN Region n=27)
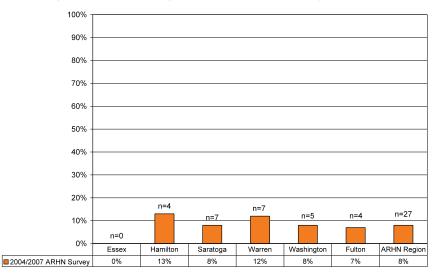
Figure 180. Percentage of Respondents Used Phone Help Line to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	n=0	n=2	n=1	n=2	n=1	n=1	n=7
2004/2007 ARHN Survey	0%	6%	1%	3%	2%	2%	2%
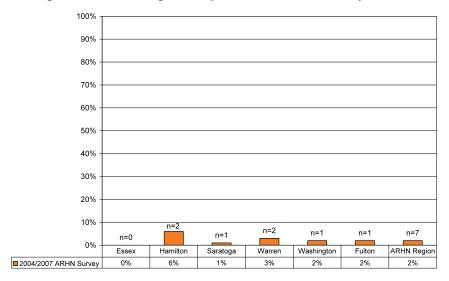
Figure 181. Percentage of Respondents Used Internet to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	n=2	n=1	n=3	n=1	n=1	n=5	n=13
2004/2007 ARHN Survey	4%	3%	3%	2%	2%	9%	4%
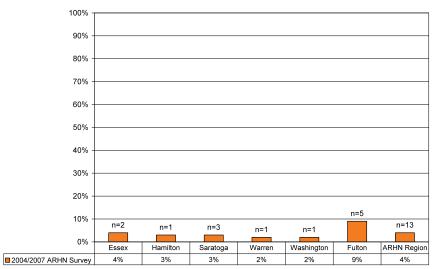
Figure 182. Percentage of Respondents Used Dr. Recommendation to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
	n=22	n=16	n=25	n=22	n=19	n=16	n=120
2004/2007 ARHN Survey	39%	50%	27%	67%	29%	30%	33%
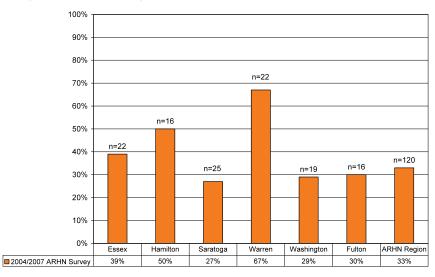
Figure 183. Percentage of Respondents Used Group Program to Quit Smoking

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	9%	6%	5%	8%	3%	2%	6%

n=5 (Essex), n=2 (Hamilton), n=5 (Saratoga), n=5 (Warren), n=2 (Washington), n=1 (Fulton), n=20 (ARHN Region)
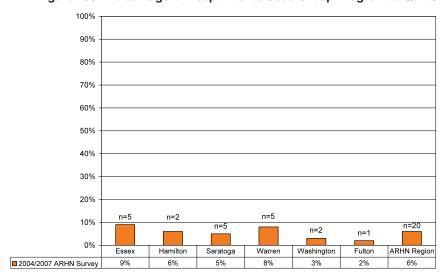
Figure 184.   Percentage of Respondents Quit Smoking with No Assistance

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	88%	84%	82%	87%	72%	80%	82%

n=50 (Essex), n=27 (Hamilton), n=75 (Saratoga), n=52 (Warren), n=47 (Washington), n=43 (Fulton), n=249 (ARHN Region)
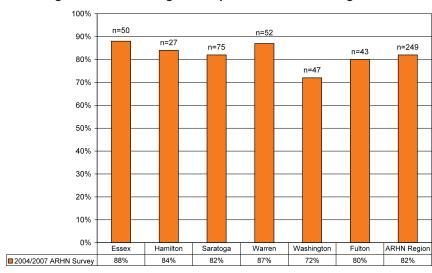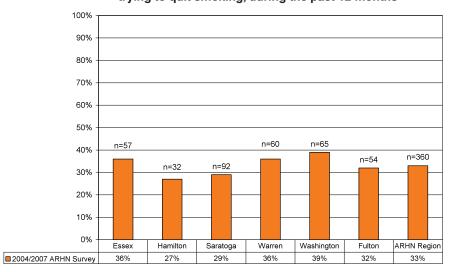
Figure 185.   Percentage of Adults who Stopped Smoking for 1 day or longer because they were trying to quit smoking, during the past 12 months

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	36%	27%	29%	36%	39%	32%	33%

n=57 (Essex), n=32 (Hamilton), n=92 (Saratoga), n=60 (Warren), n=65 (Washington), n=54 (Fulton), n=360 (ARHN Region)

Smoking Prohibited

Figure 186: In the 2008 survey the majority (77%) of regional respondents indicate that they prohibit smoking in their homes, compared to a state rate of 81%. There is some variability among counties, with Fulton reporting a low rate of 71% and Saratoga with a high rate of 81%.
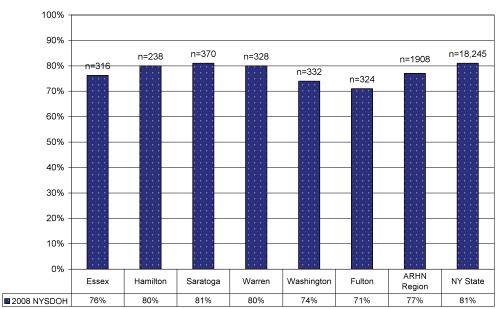
Figure 186.   Percentage of Adults Living in Homes in which Smoking is Prohibited

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	76%	80%	81%	80%	74%	71%	77%	81%

CHA Data Indicators for Tobacco Use

Tables 70-71: Of the six CHA Indicators for tobacco-related disease incidence, hospitalization, and mortality, the ARHN weighted average exceeded the Upstate or New York State average on five of the six, including lung cancer for males and females, lung and bronchus cancer incidence, CLRD (COPD) mortality, and lung and bronchus cancer mortality.

On three of the six measures, lung cancer incidence for males and females, and for lung and bronchus cancer incidence, the county rates exceeded the Upstate average for all six counties in the ARHN region. A fifth indictor, lung and bronchus cancer mortality, had five counties with higher rates that the Upstate average in 2006.

Four of the six measures are New York State Department of Health Prevention Agenda priority indicators.

The highest rate of incidence in the ARHN region is for lung cancer incidence among males, at 94.6 per 100,000 residents. The highest mortality rate in the ARHN region is for lung & bronchus cancer mortality, at 56.4 per 100,000 residents.

Table 70. Tobacco Use: Tobacco-Related Disease Incidence and Mortality, All Counties

Tobacco Related Incidence & Mortality	Essex 2004	2005	2006	Fulton 2004	2005	2006	Hamilton[3] 2004	2005	2006	Saratoga 2004	2005	2006	Warren 2004	2005	2006	Washington 2004	2005	2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
COPD hospitalizations among adults 18 + years (per 10,000)[1]			36.8			66.7			39.4			26.4			56.8			39.7	44.3	38.8		39.7	31.0	23.0
Lung cancer incidence (per 100,000) - Males[1]		94.2			102.4			138.1			89.6			92.7			103.6		103.4	94.6		80.8	62.0	85.3
Lung cancer incidence (per 100,000) - Females[1]		63.4			75.0			100.0			65.4			73.3			64.9		73.7	67.9		53.8	41.0	54.2
Lung and bronchus cancer incidence (per 100,000)[1,2]	79.4			84.7			109.2			75.2			76.9	80.9		86.9			85.4	79.0	73.2	63.2	51.5	67.7
CLRD (COPD) mortality (per 100,000)[2]	48.7	53.0	49.4	58.8	60.2	61.1	27.6	47.3	43.3	44.6	43.3	45.7	39.7	42.5	54.0	63.0	64.7	65.1	53.1	51.9	39.8			
Lung and bronchus cancer mortality (per 100,000)[2]	58.7	59.0	57.9	62.0	59.2	57.7	67.4	71.4	68.0	59.3	55.2	53.5	55.2	54.6	59.8	60.7	59.1	60.1	59.5	56.4	54.2	45.4		52.8

NOTES:

☐ County average is "Worse" than the NY Upstate or NY State average.

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events results in unstable rates for Hamilton County.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives

Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 71. Tobacco Use: Tobacco-Related Disease Incidence and Mortality, ARHN Summary

Tobacco Related Incidence & Mortality	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
COPD hospitalizations among adults 18 + years (per 10,000)[1]	44.3	38.8	Similar	2		39.7	31.0	23.0
Lung cancer incidence (per 100,000) - Males[1]	103.4	94.6	**Worse**	**6**		80.8	62.0	85.3
Lung cancer incidence (per 100,000) - Females[1]	73.7	67.9	**Worse**	**6**		53.8	41.0	54.2
Lung and bronchus cancer incidence (per 100,000)[1,2]	85.4	79.0	**Worse**	**6**	73.2	63.2	51.5	67.7
CLRD (COPD) mortality (per 100,000)[2]	53.1	51.9	**Worse**	**6**	39.8			
Lung and bronchus cancer mortality (per 100,000)[2]	59.5	56.4	Similar	**5**	54.2	45.4		52.8

NOTES:

1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives

Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Emphysema

Figure 187: The total hospital utilization for emphysema is less than 1 per 10,000 residents. There is some variability in the rates among counties, but the numbers are very small. Emphysema was not graphed by Inpatient or Ambulatory Surgery separately as all incidents were Inpatient Hospitalizations.
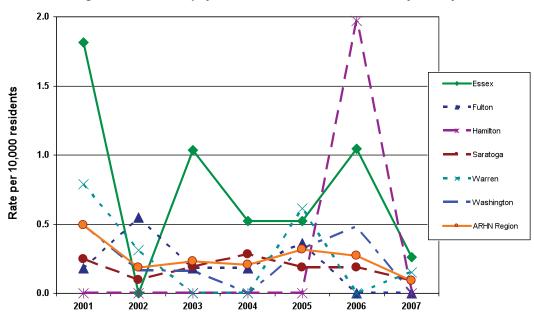
Figure 187. Total Emphysema Rate Per 10,000 Residents, by County

Trachea/Lung Malignant Neoplasms

Figure 188: The rate of hospital utilization for Trachea/Lung malignant neoplasms is increasing slightly in the ARHN region from a rate of 8 per 10,000 residents to 10 over the past six years. Inpatient utilization has remained stable, while ambulatory surgery is increasing somewhat.

Figure 189: For inpatient utilization, Hamilton, Washington and Warren counties show rates slightly above the regional averages, while Saratoga is somewhat below.

Figure 190: Ambulatory surgery utilization rates, as well as overall, most county-level rates are fluctuating, with the exception of Saratoga, which seems to be below the regional average for all six years.

Figure 191: Over the past six years, admission rates for Trachea/Lung Malignant Neoplasms have remained relatively stable for the ARHN region. Rates have averaged around 10 per 10,000 residents for the past two years. Hamilton County has shown the most fluctuation with rates varying from 10 to 20 per 10,000 residents. Saratoga County has reported admission rates consistently lower than the region over the six year period.

Figure 188. Trachea/Lung Malignant Neoplasm Rate Per 10,000 Residents, ARHN Region
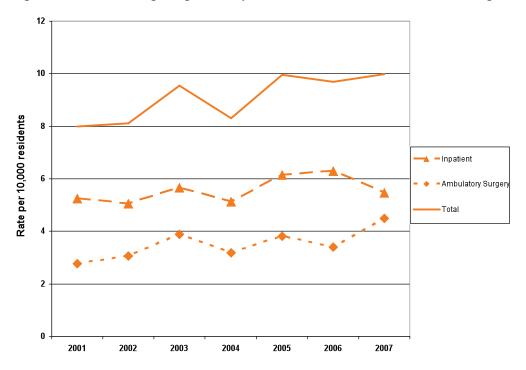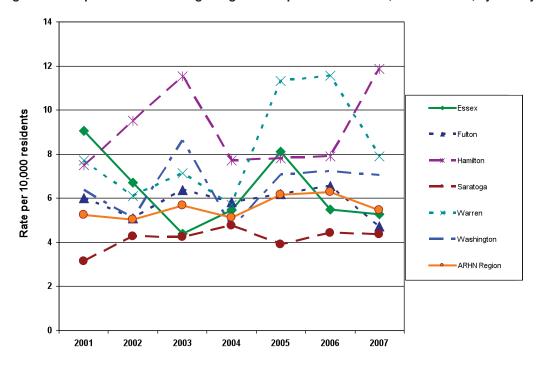
Figure 189.   Inpatient Trachea/Lung Malignant Neoplasm Rate Per 10,000 Residents, by County
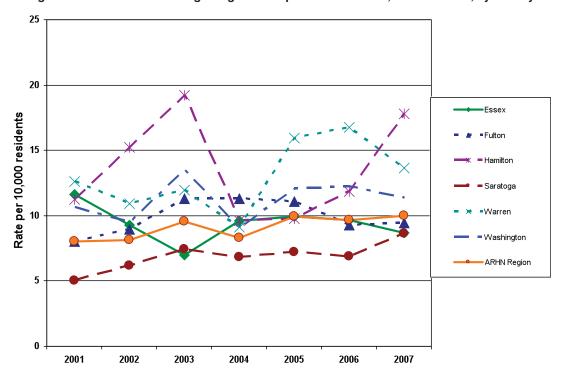
Figure 190.   Ambulatory Surgery Trachea/Lung Malignant Neoplasm Rate Per 10,000 Residents, by County

Figure 191. Total Trachea/Lung Malignant Neoplasm Rate Per 10,000 Residents, by County

Ideas Generated from Focus Groups

During the focus groups, ideas related to tobacco use and specific tobacco related diseases were not brought up by participants. Focus group feedback centered on broader community health and behaviors, and did not get disease specific. There are no focus group ideas provided under tobacco use as none were generated.

Unintentional Injury

Injury Prevention

Figure 192: In the 2004/07 survey, respondents were asked if they had ever received injury prevention instruction to prevent on the job injuries. One in five (21%) regional respondents indicated that they had. While not significantly different, Fulton County had the lowest percentage of respondents (15%) indicating that they had work-related injury prevention training, while Essex County had the highest percentage at 25%.

Figure 193: In the 2004/07 survey almost all (93%) regional respondents indicated that they always used seatbelts when riding in a car. County level rates are comparable to the regional rates.

Figure 192.   Percentage of Respondents Received Injury Prevention Instruction on the Job

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	25%	19%	21%	22%	24%	15%	21%

n=76, n=40, n=129, n=69, n=71, n=48, n=433
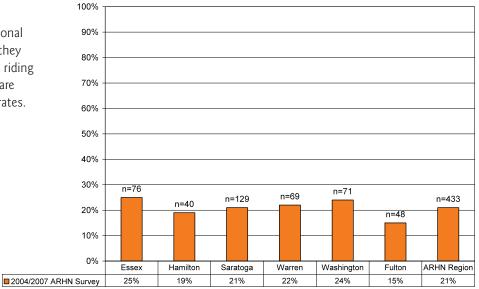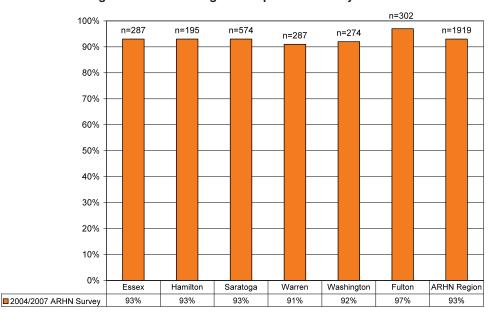
Figure 193.   Percentage of Respondents Always Use Seatbelt in Car

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region
2004/2007 ARHN Survey	93%	93%	93%	91%	92%	97%	93%

n=287, n=195, n=574, n=287, n=274, n=302, n=1919

Falls

Figure 194:   In the 2008 survey 19% of regional respondents indicated that they have had a fall within the past three months, compared to a state rate of 14%. While not significantly different, county level rates fluctuated from a low of 15% in Saratoga County to a high of 23% in Essex County.

Figure 195: In the 2008 survey, a small percentage of regional respondents (4%) at both the state and regional levels indicated they were injured by a fall. County-level results are comparable and not significantly different.
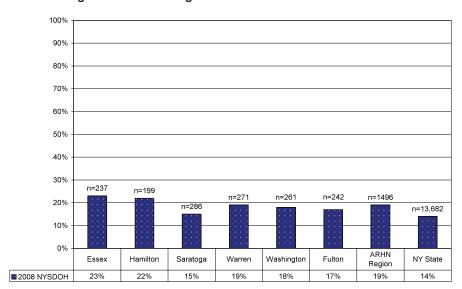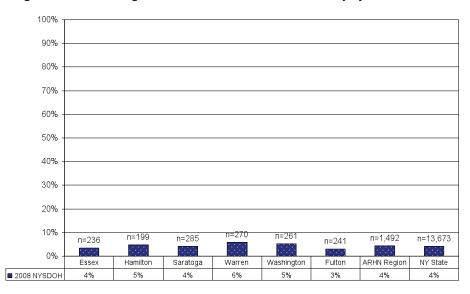
Figure 194. Percentage of Adults Had a Fall Within Past 3 Months

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	23%	22%	15%	19%	18%	17%	19%	14%

Figure 195. Percentage of Adults had a Fall that Caused Injury Within Past 3 Months

	Essex	Hamilton	Saratoga	Warren	Washington	Fulton	ARHN Region	NY State
2008 NYSDOH	4%	5%	4%	6%	5%	3%	4%	4%

CHA Data Indicators for Unintentional Injury

Tables 72-75: There were 12 CHA indicators for Unintentional Injury.

Three of the New York State Department of Health Prevention Agenda priority indicators are issues of concern in the ARHN region. Unintentional injury mortality, motor vehicle deaths, and fall-related hospitalizations each had four or more counties with rates worse than the Upstate average.

Motor vehicle deaths for the ARHN region appear to be significantly higher than the Upstate average and at 13.8 per 100,000 were over twice the New York State 2013 Goal of 5.8 per 100,000 residents.

Fulton County rates were more often higher than average, exceeding the Upstate rate for 8 of the 12 indicators.

The age group with the most injuries was the 65+ group, with 261.3 injuries per 10,000 residents.

Table 72. Unintentional Injury: Falls, Motor Vehicle and Other Injuries, All Counties

Unintentional Injuries	Essex 2004	Essex 2005	Essex 2006	Fulton 2004	Fulton 2005	Fulton 2006	Hamilton[3] 2004	Hamilton[3] 2005	Hamilton[3] 2006	Saratoga 2004	Saratoga 2005	Saratoga 2006	Warren 2004	Warren 2005	Warren 2006	Washington 2004	Washington 2005	Washington 2006	ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
Unintentional injury mortality (per 100,000)[1,2]	34.9	33.2	34.9	29.7	33.3	31.0	40.7	34.7	25.0	21.6	22.1	22.8	24.5	23.0	26.1	36.5	40.3	32.9	28.8	26.8	25.8	21.0	17.1	39.1
Unintentional injury hospitalizations (per 10,000)[1]	50.8	52.9	55.1	63.6	66.2	70.2	44.3	55.8	58.0	53.6	55.3	58.6	57.3	58.6	65.0	52.8	52.3	59.8	61.1	60.9	64.8	64.7	44.5	
Motor vehicle deaths (per 100,000)[1]	11.1	13.4	19.0	13.3	16.8	16.1	11.6		8.3	10.2	9.8	11.4	10.3	10.9	11.8	18.7	21.7	19.4	14.3	13.8	9.9	7.7	5.8	15.2
Pedestrian injury hospitalizations (per 10,000)[1]			0.2			0.6			0.0			0.7			0.7			0.6	0.5	0.6		1.9	1.5	
Fall related hospitalizations age 65+ (per 10,000)[1]			195.3			208.2			153.4			207.8			217.4			178.8	193.5	203.5		196.0	155.0	
Traumatic brain injury hospitalizations (per 10,000)[1]	4.0	4.0	3.9	9.6	10.0	9.6	5.4		7.6	6.5		7.3	5.6		5.9	6.8	6.2	6.7	6.8	7.0	8.6			
Non-motor vehicle mortality (per 100,000)	23.8	19.8	16.0	16.4	16.4	14.9	30.2	26.5	16.6	11.4	0.0	11.4	14.1	12.1	14.3	17.8	18.6	13.5	14.5	13.0	15.9		20.8	

NOTES:
☐   County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006, NYS DOH Prevention Agenda

Table 73. Unintentional Injury: Falls, Motor Vehicle and Other Injuries, ARHN Summary

Unintentional Injuries	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up-state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Unintentional injury mortality (per 100,000)[1,2]	28.8	26.8	Similar	4	25.8	21.0	17.1	39.1
Unintentional injury hospitalizations (per 10,000)[1]	61.1	60.9	Better	2	64.8	64.7	44.5	
Motor vehicle deaths (per 100,000)[1]	14.3	13.8	**Worse**	**5**	9.9	7.7	5.8	15.2
Pedestrian injury hospitalizations (per 10,000)[1]	0.5	0.6	Better	0		1.9	1.5	
Fall related hospitalizations age 65+ (per 10,000)[1]	193.5	203.5	Similar	4		196.0	155.0	
Traumatic brain injury hospitalizations (per 10,000)[1]	6.8	7.0	Better	1	8.6			
Non-motor vehicle mortality (per 100,000)	14.5	13.0	Similar	2	15.9		20.8	

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Table 74. Unintentional Injury: Hospitalizations by Age Group, All Counties

Unintentional Injury Hospitalizations by Age Group	Essex			Fulton			Hamilton[3]			Saratoga			Warren			Washington			ARHN Avg[4]	ARHN Wght'd Avg[5]	Up-state Avg	NYS Avg	NYS 2013 Goal[6]	U.S. Avg
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006						
Unintentional injury hospitalizations age <10 (per 10,000)	10.5	9.0	5.5	30.0	33.3	36.8	7.0	14.9	22.3	17.6	18.9	19.9	11.8	15.2	18.1	19.7	22.7	25.1	21.3	21.3	23.6			
Unintentional injury hospitalizations age 10-14 (per 10,000)	23.5	20.9	20.2	24.9	25.5	30.3		23.1	48.1	11.9	10.0	15.5	17.2	20.6	22.3	26.5	26.8	28.0	27.4	20.9	22.7			
Unintentional injury hospitalizations age 15-24 (per 10,000)	28.3	28.0	39.2	32.5	37.4	51.6	5.7	5.5	12.0	24.4	25.6	34.5	24.2	23.3	38.8	31.8	27.0	34.8	35.2	37.4	36.9			
Unintentional injury hospitalizations age 25-64 (per 10,000)	29.9	35.4	33.6	41.3	45.1	49.5	40.5	48.1	49.7	30.3	31.9	35.0	40.4	40.5	42.8	32.5	33.4	39.9	41.8	38.7	44.5			
Unintentional injury hospitalization age 65+ (per 10,000)	233.0	234.3	253.2	276.3	276.3	272.3	185.9	217.3	216.0	253.0	263.0	264.7	252.1	259.1	277.5	215.3	212.3	231.2	252.5	261.3	269.8			

NOTES:
☐ County average is "Worse" than the NY Upstate or NY State average.
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Low population and a small number of events means that the rates for Hamilton County can be unstable.
4. Adirondack Rural Health Network (ARHN) average is a straight average of the individual county rates, with each of the six counties contributing equally.
5. The weighted average accounts for population differences between counties to compute an average rate for the population of the ARHN area (443,837 in 2008).
6. NYS Prevention Agenda 2013 Objectives
Data Sources: NYS County Health Assessment Indicators (CHAI), New York State Community Health Data Set – 2006

Table 75. Unintentional Injury: Hospitalizations by Age Group, ARHN Summary

Unintentional Injury Hospitalizations by Age Group	ARHN Avg[3]	ARHN Wght'd Avg[4]	How ARHN Compares to Upstate / NY Avg[5]	# of ARHN Counties Worse than Upstate Avg[6]	Up- state Avg	NYS Avg	NYS 2013 Goal[7]	U.S. Avg
Unintentional injury hospitalizations age <10 (per 10,000)	21.3	21.3	Similar	2	23.6			
Unintentional injury hospitalizations age 10-14 (per 10,000)	27.4	20.9	Similar	2	22.7			
Unintentional injury hospitalizations age 15-24 (per 10,000)	35.2	37.4	Similar	3	36.9			
Unintentional injury hospitalizations age 25-64 (per 10,000)	41.8	38.7	Better	2	44.5			
Unintentional injury hospitalization age 65+ (per 10,000)	252.5	261.3	Similar	2	269.8			

NOTES:
1. NYS DOH Prevention Agenda Indicator, 2009
2. NYS DOH CHA Core Indicator, 2005
3. Adirondack Rural Health Network (ARHN) average is a straight average of the rates for each of the six counties.
4. The weighted average computes an average for the ARHN-area population as a whole (443,837 in 2008).
5. Comparative references are: Similar, Better or Worse; Similar is used if the difference is less than 3.0 (or 30.0 for rates >100).
6. The most recent year's data is used to tally the counties that are "Worse" than the Upstate average or the NYS average if the Upstate value is not available. The number of counties is highlighted in bold if more than half the counties (i.e., 4 or more).
7. NYS Prevention Agenda 2013 Objectives
Sources: NYS County Health Assessment Indicators (CHAI), NYS Community Health Data Set, NYS DOH Prevention Agenda

Unintentional Injuries

Figure 196: Hospitalizations for all types of unintentional injuries have been increasing with the general category of Other Injuries being of highest priority. This category includes a wide range of injuries not included in the other groups. Interestingly, Poisoning injuries is increasing rapidly and emerging as a priority. Volume of Fractures remain stable as a significant portion of the injuries observed.
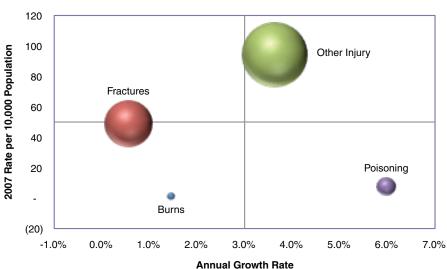
Figure 196. Summary Unintentional Injuries, ARHN

Fractures

Figure 197: Hospital utilization related to fractures has remained relatively constant from 2001 to 2007, around 48 per 10,000 residents. While there has been some slight fluctuation for inpatient utilization, the rates have remained around 33 per 10,000 residents.

Figure 198: Saratoga County's inpatient utilization has been slightly below the regional average; all other county data has fluctuated around the average.

Figure 199: Ambulatory surgery rates for fractures have remained relatively consistent.

Figure 200: Saratoga and Essex counties have remained below average in terms of regional utilization.
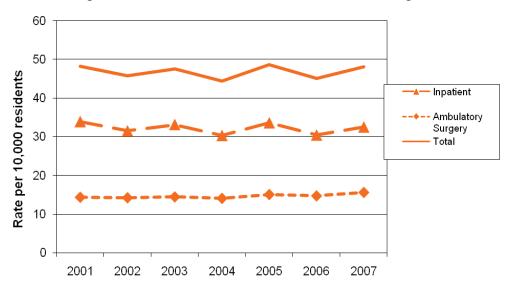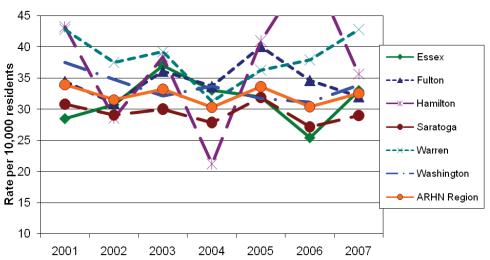
Figure 197.   Fracture Rate Per 10,000 Residents, ARHN Region

Figure 198.   Inpatient Fracture Rate Per 10,000 Residents, by County
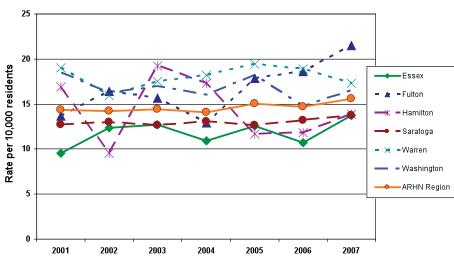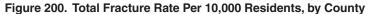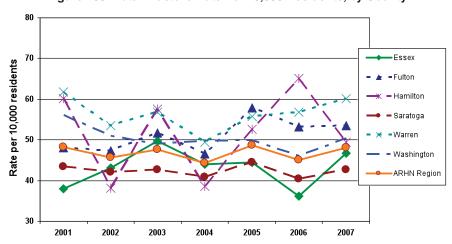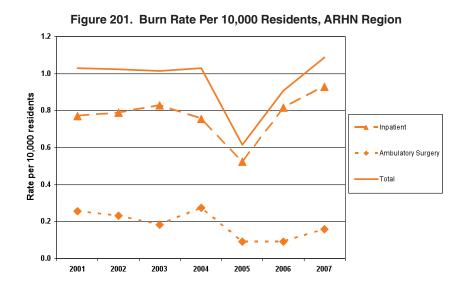
Figure 199. Ambulatory Surgery Fracture Rate Per 10,000 Residents, by County

Figure 200. Total Fracture Rate Per 10,000 Residents, by County

Burns

Figures 201-204: Burns have relatively low rates of hospital utilization, generally around 1 per 10,000 residents. Because of the small numbers, there appears to be a great deal of fluctuation, but it is not significant, as the utilization numbers are very low in all counties.

Figure 201. Burn Rate Per 10,000 Residents, ARHN Region

Figure 202. Inpatient Burn Rate Per 10,000 Residents, by County

Figure 203. Ambulatory Surgery Burn Rate Per 10,000 Residents, by County
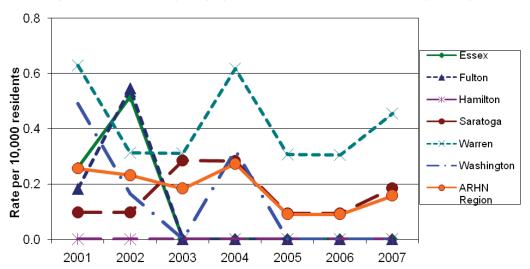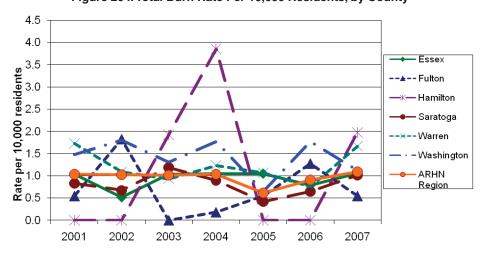
Figure 204. Total Burn Rate Per 10,000 Residents, by County

Poisoning

Figures 205-207: The total hospital and inpatient utilization rates for poisoning is identical, as there is virtually no ambulatory surgery utilization for this condition. Rates have increased slightly over the past six years, trending up from about five to seven per 10,000 residents. Saratoga County is the only county that is consistently below the regional average in terms of utilization during this six year period.
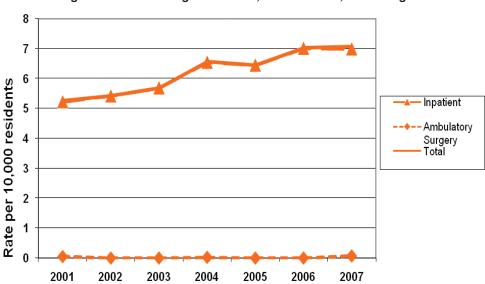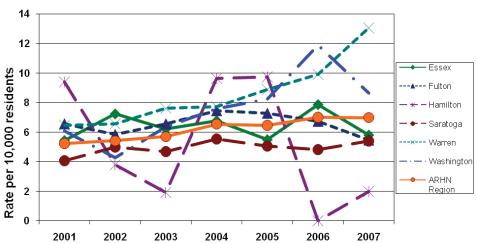
Figure 205.   Poisoning Rate Per 10,000 Residents, ARHN Region

Figure 206.   Inpatient Poisoning Rate Per 10,000 Residents, by County
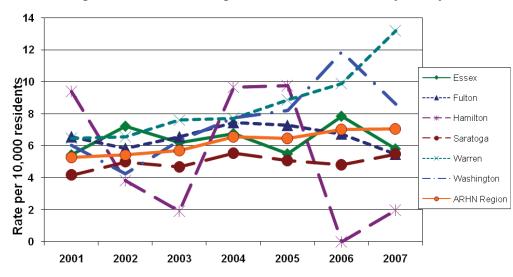
Figure 207. Total Poisoning Rate Per 10,000 Residents, by County

Other Injuries

Figure 208: The total rate of hospital utilization for other injuries has been increasing slightly over the past six years, rising from around 79 per 10,000 residents up to over 90. While lower than the ambulatory surgery rates, the rate of inpatient hospital utilization has increased slightly from 2001 to 2007.

Figure 209: For inpatient utilization, the county rate trends generally mirror the overall average, with the exception of Hamilton County, where the rate is somewhat higher than the other counties, and fluctuates a little more. Essex and Saratoga County rates are somewhat lower than the regional average.

Figure 210: For ambulatory surgery, Saratoga and Warren counties have rates that are slightly above the regional average, although the rate in Warren County has fluctuated below the regional average.

Figure 211: For the Counties of Essex, Fulton and Hamilton the rates are somewhat lower than the regional average.
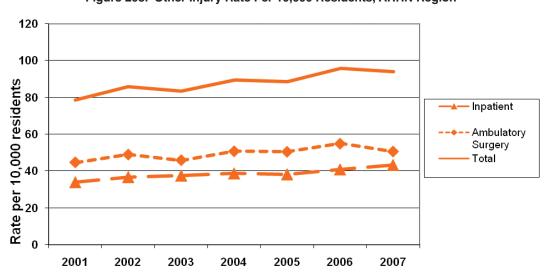
Figure 208. Other Injury Rate Per 10,000 Residents, ARHN Region
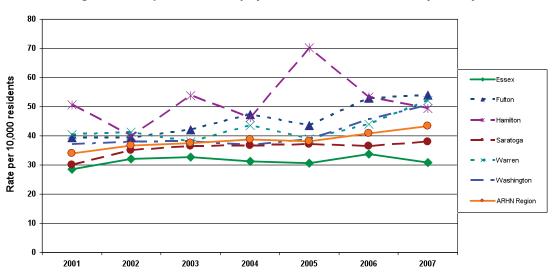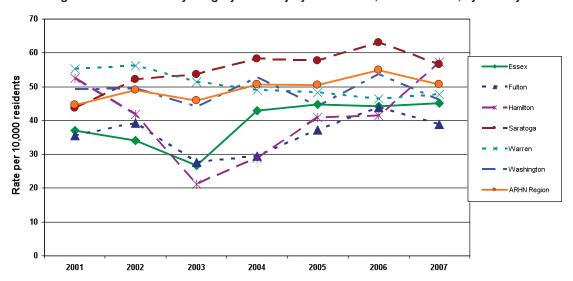
Figure 209.   Inpatient Other Injury Rate Per 10,000 Residents, by County

Figure 210.   Ambulatory Surgery Other Injury Rate Per 10,000 Residents, by County
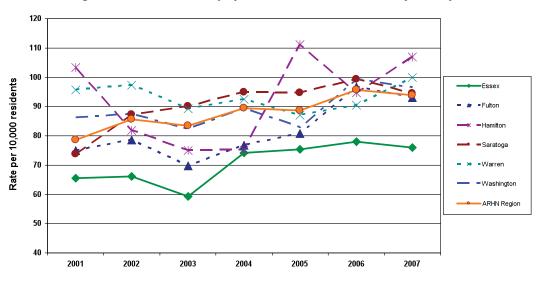
Figure 211. Total Other Injury Rate Per 10,000 Residents, by County

Ideas Generated from Focus Groups
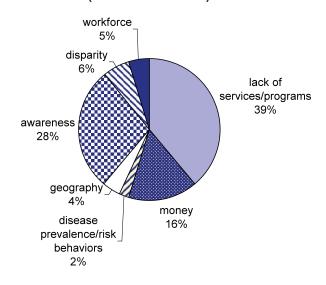
During the focus groups, ideas related to specific injuries were not brought up by participants. Focus group feedback centered on broader community health and behaviors, and did not get disease/injury specific. There are no focus group ideas provided under inintentional injury as none were generated.

Stakeholder Focus Group and Input

Barriers

Figure 212: During the focus groups participants were asked to identify barriers to accessing health care in their community. These barriers were placed into overall barrier categories. Lack of services and programs (39%) was suggested to be the greatest barrier, followed by awareness (28%), money (16%), disparity (6%), workforce (5%), geography (4%), and lastly disease prevalence/risk behaviors (2%).

Figure 212.   ARHN Community Health Assessment Barriers (369 Total Comments)

Priorities

This section provides a summary of the top ten themes and single items from the focus groups. Individual responses for Prevention Agenda related items are found throughout the main study and are listed below:

The Access to Care section:

- Doctors/Providers
- Transportation
- Insurance
- Technology
- Elder Care
- Hospitals
- Resources & Referral Networks
- Pharmacy
- Screenings/Prevention
- Van/Mobile Health Care
- Health Literacy
- Dental Care

The Healthy Environment section:

- Environmental Issues

The Healthy Mothers, Healthy Babies, Healthy Children section:

- Parenting/Family Education
- Youth Services
- Youth/Brain Drain

The Mental Health and Substance Abuse section:

- Alcohol/Substance Abuse
- Mental Health

The Physical Activity and Nutrition section:

- School Districts
- Promote Prevention & Wellness
- Food/Eating Habits
- Walk and Bike Paths
- Employer Programs/Workplace Health

Figure 213: Focus group participants were asked to discuss and vote upon priorities for creating a healthy community. These ideas were grouped into themes. Suggestions related to school districts received the highest number of votes (171), followed closely by governments (168).

Figure 214: The top 10 single item themes from focus groups. The bars are coded based on the theme they belong with. The top ideas include creating a free clinic, more funding for school programs, and improving transportation. Three of the suggestions fall under government, two relate to school districts, and the other items are each related to one of the themes.
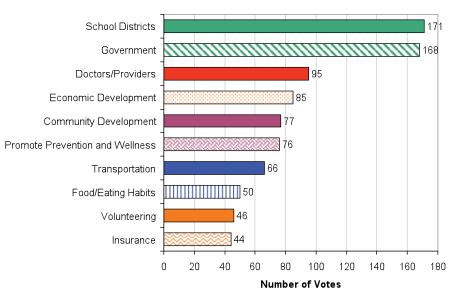
Figure 213.   Top 10 Themes from Focus Groups
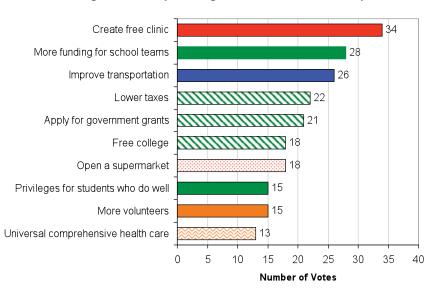
Figure 214.   Top 10 Single Items from Focus Groups

Number of Votes

Community/Policy Change Ideas

The following suggestions from the focus groups relate to community/policy change ideas. Government received the second highest number of overall votes (168).   Any feedback from the focus groups that did not fit into a previous section of the study can be found below.   Suggestions include lowering taxes, applying for government grants, providing free college, opening a supermarket, supporting collaboration, and developing programs.

Government (168)

- Lower taxes (22)
- Apply for government grants (21)
- Free college (18)
- Increase funding to support new water and air systems (12)
- Streamline and simplify local government- shared services governance (8)
- Permanent moratorium on state land purchases/ easements (8)
- Eliminate all un-funded state programs (7)
- Know your politicians – vote knowledgeably (7)
- Change formula for receiving funds from state and federal government (6)
- Revamp state land use master plan (5)
- Allow local/county government to run our towns (5)
- Government needs to reassess funding/ spending allocations (5)
- Less red tape and hoops to be jumped through (4)
- Advocate for equitable local zoning that allows for growth and still maintains uniqueness of town (3)
- Make politicians more aware (3)
- Change legislation on tax laws to help & keep business in the area (3)
- Raise taxes on gasoline to provide revenue for universal health care (3)
- Let us be part of the plan – not the result of (2)
- Place an increased tax on fast food places (2)
- Need help from our legislators – make them aware of senior needs, especially health & transportation (2)

- Stop funding projects that don't work and put $$ toward those that do (2)
- Have town board set aside money every year for improvements – could be held over to next year's budget for larger amounts (2)
- Allow private sector to manage state parks & programs (1)
- Restructure APA Act to expand communities (Hamlets) (1)
- Town Hall meeting to discuss changes – Include all ages (1)
- A tax policy that promotes the development of healthy spaces and healthy private enterprise – i.e.: subsidies for healthy farmer's markets, not Wal-Mart (1)
- Community Action Group Meetings/Get togethers for healthy changes in the community (1)
- Send in letters to public works about where pot holes are (1)
- Involvement in political issues (1)
- More appropriate use of available funding (1)
- Government needs to think realistically (treat it as if it was their check book) (1)
- Laws in place for all new construction/ roadways to be bike & pedestrian friendly – planners/ DOT/ lawmakers (1)
- If we require something, we must give aid to perform it (1)
- Bring my view to the ones in power of town (1)
- Increase easily accessible grant funding (1)
- Tax credit for rural living – to offset the extra cost of goods and services (1)
- Increase funding for water & sewer (1)
- Increases taxes on alcohol & cigarettes (to pay for programs) (1)
- Establish government regulated health & dental care (1)
- Less "red tape", more service (1)

Economic Development (85)

- Open a supermarket (18)
- Increase job opportunities (9)
- Encourage state agencies to consider facilities in this area, college, prison, state parks, seniors & disabled facilities (8)
- Comprehensive economic development plans/ initiatives address jobs, housing, education (5)
- Low cost energy solutions for individual homeowners (3)
- Tourism – builds things to bring people here – i.e.: Use the canal (3)
- Renovation of empty buildings with promise to use for specific area (youth, seniors, childcare, etc.) (3)
- Reduce the cost of operating small business in New York State (3)
- Lower taxes – low cost dental (3)
- Create new businesses in Whitehall (3)
- Increase minimum wage to $10 per hour (2)
- Host town-wide garage sale in Whitehall (2)
- Tax incentives for companies providing nutritional counseling (2)
- Lower assessment on seniors (2)
- Easier to get loans (2)
- Establish tax credits for caregivers (2)
- Budget (1)
- Upgrade road services (1)
- Open a department store (1)
- Donations (1)

- Make village budget more efficient (1)
- Increase funding for businesses (1)
- Increase tax base for business in town or village (1)
- State and Federal money incentives for businesses to come to this area (1)
- Increase advertising of our area to other populations (1)
- $$ saved by pulling together (1)
- More money (1)
- Follow through on more available parking in resort areas and shuttle service (1)
- Use canal & rail system to bolster economy (1)
- Bring back "green thumb" programs for young retirees (1)
- Funding of service models that account for rural realities (1)

Community Development (77)

- Identify community residents perceptions on their needs and how to access (6)
- More leadership locally (6)
- Have a town make-over day (flowers, paint, etc.) (5)
- Everybody helping one another (5)
- People need to do more for themselves (5)
- Create a community center so the people can have something to do and interact - make that a community project (4)
- We need to look at what is already working to create better choices/ results. (3)
- Individuals must be willing to be involved (3)
- Community storage/ exchange of sports/ exercise equipment (3)
- Clean up the streets (2)
- Construct a "Central Plaza" where people congregate and public resources are available - i.e.: Market, open in winter & summer (2)
- Hire consultants to help with planning (2)
- Identify geographical areas in county to be hubs of information (2)
- Recruit more diverse community (2)
- Community partners need to meet more and share information (2)
- Make centralized service center & activities (2)
- More fund raising (2)
- The family unit needs to be the center again - take care of young and old (2)
- There should be more non-competitive community effort (2)
- Host cultural activities (2)
- Have more community get togethers (1)
- Bring my views to the ones in power in town (1)
- More community centers (1)
- Develop need for community involvement at a younger age - not just for adults (1)
- Start a public event committee and get started hosting outdoor events (1)
- Create citizen action committee (1)
- Local public TV station (1)
- Host broadcasts and radiocasts to promote community (1)
- Hold community ethnic day to learn about other cultures (1)
- Create organized volunteer groups for community clean up and maintenance (1)

- Community needs must be publicized (1)
- More meetings to discuss community needs (1)
- Build a foundation to educate (1)
- Have more community meetings (1)
- Promote "old" neighborhood - serving others in need/ playgrounds (1)

Volunteering (46)

- More volunteers (15)
- Bring senior citizens into school as support (reading, helping out) in classroom (6)
- Use volunteers whenever possible and seek them out (4)
- Consider specific amount of volunteering as a requirement of a course, graduation & tax break (4)
- Phone volunteers to call & visit with "shut-ins" (3)
- Announce volunteering opportunities publicly so people know where to go to volunteer (3)
- Help with resources by offering middle school/high school students course credit for volunteering for community organizations to gain resources (Or create a mandatory class.) (2)
- Train & enlist volunteers to help in many areas (2)
- Provide incentive for volunteering - example: college credit for summer youth recreation programs (2)
- Encourage volunteer programs for driving or maintaining bike or walking trails (1)
- Volunteers active (1)
- Promotion of mentor programs for youth and adults (1)
- Tax credit or some incentive for volunteering (1)
- Create volunteer groups to use skills to build neighborhood playgrounds (1)

Advocacy (41)

- Train community members in the skill of advocacy (6)
- Educate the community re: the culture of poverty (5)
- All levels of government officials should be immersed in low income living conditions (4)
- More public involvement - less complaining (4)
- Accountability - health- own personal finances (3)
- More involvement for senior citizens (2)
- Attend more town meetings (2)
- Muzzle the APA, so call service, reasonable industry can be developed (2)
- Become stronger advocates with our politicians - letter writing campaign, attendance @ meetings (2)
- Develop and conduct health literacy 101 train the trainer workshops (1)
- Stand Up - Vote (1)
- Support who is down or struggling (1)
- Take pride in yourself and community (1)
- Get more focus with the people around me to help more (1)
- Work toward universal health coverage with local representatives (1)
- Speak up and don't give up - ask for help (1)
- Create forums to encourage more people to vote (1)
- Starting my own group with people that I know (1)
- Increase political advocacy for rural areas (1)
- Be a more active community member by attending town board/ school board meetings (1)

Regional Coordination (27)

- Getting APA to cooperate and encourage development to sustain a community (11)
- Get more disciplines involved - educators, healthcare, businesses, police (4)
- Contacts available in Albany or local that will bring issues to seniors (4)
- Centralize/ coordinate all health services to decrease duplication and improve prioritization (3)
- More involvement by under 50 population (2)
- Each partner needs to look outside its' "silo" (1)
- Cooperation among various agencies (1)
- Centralized healthcare for Medicaid clients - one site for all MD, Rx, mental health, etc.; incorporate education in health, diet, etc. in waiting environment; include cafeteria staffed by people who are being trained to do this type of work(1)

Other (24)

- Give respect (4)
- Stop procrastinating (3)
- Set goals (2)
- Listen (2)
- Free pet care programs - spay, neuter, etc. (2)
- Free access to generators when the power goes out (2)
- Legislative (special needs) (1)
- Care (1)
- Make Plans (1)
- Support and nurture local media/ cable access (1)
- Tuition program to support college enrollment (1)
- Let's see more common sense in decisions (1)
- Personal responsibility (1)
- Public needs to learn fiscal responsibility (1)
- Inner personal values need to improve (1)

Interagency Collaboration (23)

- One central location to obtain information (8)
- Increased coordination between community agencies (hospitals, public health, etc) (6)
- County-wide approach so not to isolate activities by small communities (3)
- Improve collaboration among service providers (3)
- Support family/neighborhood activities (1)
- Create "community health committee" to increase health options locally (1)
- Combine efforts to provide community wellness directory (1)

Workforce (18)

- Recruit & retain next generation of medical staff professionals (5)
- Start and support new business for possible new jobs in future (5)
- More jobs for county (2)
- Local colleges provide curriculums for much needed occupations in our region - OT, PT, TVI, ABA training (2)
- More handymen (1)

- All health care providers need to promote health career opportunities with youth to expand health care workforce (1)
- More trade schools, more work/ college programs; 3 months work + 3 month college training (1)
- Provide funding models for the recruitment & retention of medical professionals (1)

Housing (16)

- Affordable housing and incentive programs (8)
- Accountability for absentee landlords (2)
- Develop older homes (2)
- Affordable housing for seniors in village (2)
- Eliminate obstacles to create affordable housing (1)
- Build affordable housing with landlords that will keep up with maintenance (or fine them) (1)

CHA Process (7)

- Survey community members about issues important to them. (4)
- Survey for people's thoughts - find out what people want (1)
- Committees to go through these ideals for the most needed first (1)
- Communities need to address health from a health disparities/ health inequalities perspective (1)

Adult Education (7)

- College opportunities (3)
- Provide more workshops for community (2)
- Bring education classes to rural communities (1)
- Educate adults on health issues (less educated people) (1)

Law Enforcement (5)

- Law enforcement in school to combat drugs (2)
- More police to keep our community safe (1)
- Harder laws for animal cruelty (1)
- Better police coverage: Better to handle large influx of tourist activities; i.e. - fireworks, car show, etc. (1)

Home Health (1)

- Public health or home care - response to relieve pressure on EMS (1)

Domestic Violence (1)

- Train medical, clinical and other youth serving professionals to screen for teen dating violence (TDV) (1)

Areas of Opportunity for Community Health Improvement

Based on the information gathered in this community health assessment, the community service plan, and the guidelines set forth in the New York State Prevention Agenda and Healthy People 2010, the Committee reviewed all of the information presented in this study. On June 5, 2009 the Committee convened to discuss and analyze the health indicator information contained in this study including stakeholder focus group findings. This section describes the process that was used to identify health priorities.

Priority Setting Process

There are various mechanisms through which organizations identify priority health issues. This can be accomplished through community direction and feedback; through analyses of primary and secondary data; or a combination of the two. Regardless of which mechanism is applied, a variety of criteria must be considered when identifying priority areas. No single criterion determines a specific area of need. Rather, the relationship among the criteria is considered in identifying priority areas.

The prioritization matrix was chosen as the best method to identify the priority health issues for the Adirondack Rural Health Network's six-county area. Using a prioritization matrix rather than simple voting provides a more confident selection when there is data available to help score criteria and issues. An ad-hoc committee was convened to develop the criteria for the matrix. The ad-hoc committee researched a variety of prioritization matrices and compiled a list of 25 possible criteria that could be used to rate and rank health issues. After considerable discussion, the following eight criteria were agreed upon:

- Leadership support available
- Magnitude of the problem
- Variance against benchmarks or goals
- Importance to the public health system

- Impact on other health outcomes
- System resources available
- Impact on the physical or social environment
- Ease of implementing solutions

Four of the criteria were weighted to reflect their added importance as determined by the committee: leadership available, magnitude of the problem, variance against benchmarks and system resources available.

By rating each health issue on a 1-to-10 scale based on their importance with respect to each of the eight criteria, a value for each health issue can be identified. The individual values for each health issue are then combined to create a score that can be rank ordered by importance. This prioritization matrix tool is important because it treats the criteria independently, helping avoid an over-influence or emphasis on specific individual criteria.

The matrix itself was constructed with the health issues listed along the side and the review criteria along the top. A box to insert the specific assigned rating is located with each criterion. An evaluation scale is established for the whole matrix. The rating of a specific health issue based on its response to each criteria is entered into the appropriate cell. The total scores are then available to use as ranking alternatives. This is typically a very tedious, mathematical

process for participants when conducted using hand votes and spreadsheets. In order to streamline the process and the mathematical calculations, the OptionFinder audience response polling system was utilized to collect and tabulate the data. The wireless OptionFinder provides a democratic and anonymous polling system that simultaneously captures and analyzes the response of each participant. The results can then be immediately displayed on a projector screen for review and further discussion.

Identified Health Priorities

The regional community health assessment and community service plan data collection and reporting process identified 34 distinct health issues for prioritization. The Committee used the OptionFinder to rate each of the issues on each of the eight criteria, as outlined above. The scores for the 34 individual health issues were then placed into each of the ten NYSDOH Prevention Agenda areas. Diagram 3 illustrates the final score of each of the ten areas.

Many of the ten health priority areas were very close in their ranking. In order to be precise in their decision-making, the Committee completed a paired comparison exercise. In this exercise the Committee used the OptionFinder to compare the top six health areas against each other, determining the higher priority area in each case. The results of all the paired comparisons were tallied and the list of priority areas were re-ordered into the final list of the top six priority health areas for the region, as illustrated at left.

Diagram 3

Prevention Agenda Areas	Score
Tobacco Use	72.75
Community Preparedness	59.45
Physical Activity & Nutrition	58.78
Chronic Disease	57.05
Infectious Disease	56.12
Access to Quality Health Care	54.72
Healthy Mothers, Healthy Babies & Healthy Children	50.55
Healthy Environment	47.68
Mental Health & Substance Abuse	44.35
Unintentional Injury	40.87

Final Paired Comparison

Prevention Agenda Areas	Score
Physical Activity & Nutrition	76.8
Chronic Disease	66.3
Access to Quality Health Care	61.1
Tobacco Use	40.0
Community Preparedness	27.4
Infectious Disease	27.4

Top Priority Issues

The overall results of the weighted prioritization and paired comparison exercises identified the following three health areas as top priorities in the six-county ARHN area:

- Physical Activity and Nutrition
- Chronic Disease
- Access to Quality Health Care

Of these three, Physical Activity and Nutrition is the health priority area that the Committee members agree to focus on over the next several years. Each of the health departments and hospitals will also select additional priorities requiring their attention over the next several years. Details regarding the Committee's plans to address priority health issues, identify opportunities, and involve stakeholders and the public are outlined in the next section.

Regional Action Plan

Creating a healthier region requires collaboration between many regional partners. The Committee is recognized as a leader in community health planning and has established strong connections. Purposeful collaboration has built unity, clarified direction, and achieved measurable health improvements. There is energy and enthusiasm that will continue to strengthen as the partnerships grow. The region will continue to benefit from the strong community leveraging this Committee has already initiated.

The efforts of the Committee are comprehensive and coordinated and go beyond the individual to focus on the community. Each member of this group has demonstrated leadership and accountability for ongoing regional planning, implementation and evaluation. The ongoing call to action is to continue building community relationships and strengthen leadership which will build upon the foundation for a healthier region.

Regional coordination of this process has been evolving for the ARHN over the past six years. It is an ongoing process which took a major step forward in 2009 when the hospitals in the six-county area became directly involved with the regional planning process. The hospitals' involvement brought a new set of data, experiences, and resources to the table which complemented the expertise of the public health officials and other stakeholders who have been participating in the process since 2003. As a result, the region now has a community health assessment document that is coordinated with the hospital community service plan. This approach provides much greater insight into the region's community health issues.

While dedicated to improved community health at the regional level, each member of the Committee has specific responsibilities to their own agencies, institutions, and governing bodies, as well as to the NYSDOH. While the committee members have agreed to focus on Physical Activity and Nutrition as a regional priority issue, their individual organizations will each have additional priority health issues to focus on over the next four years. It is likely those priorities will be drawn from the list of the top six regional priorities as presented above; however, any of the ten Prevention Agenda areas could be selected.

To those not familiar with the regional CHA and CSP process, it might be difficult to conceptualize how so many organizations will work together on a regional issue while simultaneously addressing a number of other health issues at the facility, community, or county level.

Diagram 4 provides an illustration of how all the county health departments and area hospitals come together to address the shared regional health priority of Physical Activity and Nutrition. Beyond that a particular county and a particular hospital might share a priority issue and plan to work together to address it.

The largest area in the diagram represents all of the public health departments in the ARHN area on the left side, and all of the hospitals on the right, indicating where shared priorities and activities might overlap to address mutual goals.
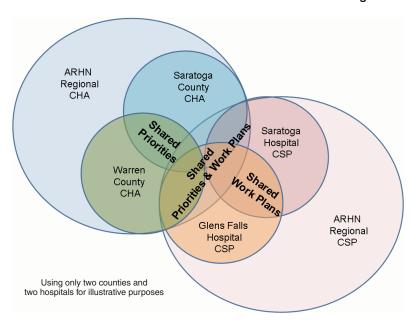
Diagram 4. Overview of Community Health Planning for the multi-County, multi-Hospital CHA and CSP for the Adirondack Rural Health Network Region

Regional Action Plan

Commitment and energy of community partners is a good first step in the process of addressing the top regional priority health issue. The second step is setting objectives and formulating an action plan to manage and sustain the process. The following outcomes are identified as steps to positively impact physical activity and nutrition in the region:

Outcome 1: Establish a taskforce of regional representatives whose goal is to select activities, design an implementation schedule and select a method of evaluation for evidence-based programs focusing on physical activity and/or nutrition by January 1, 2010 for Year 2 and 3 implementation.

Outcome 2: Develop a workplan with measurable outcomes, implementation schedules and budgets by June 30, 2010.

Outcome 3: Physical activity and/or nutrition interventions are implemented by taskforce members by June 30, 2011.

Outcome 4: Physical activity and/or nutrition interventions are evaluated and results are communicated to stakeholders by June 30, 2012.

Regional efforts will continue with the community building on its successes, setting new goals, initiating new activities and continuing the process of improvement.

Glossary of Terms

A

Access to Health Care

The timely use of personal health services to achieve the best possible outcomes. It can include, but is not limited to, availability of information, care, public or private insurance coverage, transportation, culturally and linguistically competent care, and other factors that affect personal and cultural decisions related to seeking health care services.

Actual Causes of Death

While the leading causes of death are heart disease, cancer, stroke, and respiratory disease, the actual causes of death are defined as lifestyle and behavioral factors such as smoking and physical inactivity that contribute to this nation's leading killers. Physical inactivity and poor nutrition is catching up to tobacco at the top of the list of actual causes of death. In 2000, the most common actual causes of death in the United States were tobacco (435,000), poor diet and physical inactivity (400,000), alcohol consumption (85,000), microbial agents (e.g., influenza and pneumonia, 75,000), toxic agents (e.g., pollutants, asbestos, etc., 55,000), motor vehicle accidents (43,000), firearms (29,000), sexual behavior (20,000) and illicit use of drugs (17,000).

Adjusted Rates

Adjusted rates are summary rates constructed to permit fair comparison between groups differing in some important characteristics such as age, sex or race. When comparing the rate of disease between two or more counties, adjusted rates standardize the composition of their populations so that the influence of ethnic, racial, or age differences is minimized. Adjusted rates are also referred to as standardized rates and can be contrasted with "crude rates" where there have been no adjustments to the data.

Age

The number of complete years an individual has lived. The age classification is based on the age of the person at his or her last birthday.

Age-Adjusted Death Rate

Death rate of a group calculated as a weighted average of the age specific death rate of the same group. The age distribution of a population for a given period of time is called the standard population. In this report the standard population is the census count of the United States in 2000.

Age Adjusted Rate

Age-adjustment is a statistical process applied to rates of disease, death, injuries or other health outcomes which allows communities with different age structures to be compared.

Assessment

One of public health's three core functions, the others are policy development and assurance. It is the regular collection, analysis and sharing of information about health conditions, risks and resources in a community. Assessment is needed to identify health problems and priorities and the resources available to address the priorities.

Asset Mapping

A tool for mobilizing community resources. It is the process by which the capacities of individuals, civic associations, and local institutions are inventoried.

Assurance

One of the three core functions in public health, the others are assessment and policy development. It is the process of making sure that all populations have access to appropriate and cost effective care, including health promotion and disease prevention services. The services are assured by encouraging actions by others, by collaboration with other organizations, by requiring action through regulation, or by direct provision of services.

Attributable Risk

The arithmetic or absolute difference in incidence rates between an exposed and non-exposed group.

B

Baby Boom

People born during 1946 to 1964 (post-WWII) are referred to as "baby boomers" or the baby-boom generation.

Behavioral Risk Factors

Behaviors which are believed to cause, or to be contributing factors to, accidents, injuries, disease, and death during youth and adolescence and significant morbidity and mortality in later life.

Benchmarks

Indicators of progress that tell us whether elements of a long-term strategic plan are being achieved.

Best Available Evidence

Conclusive evidence of the links between, for example, socio-environmental factors and health or the effectiveness of interventions is not always available. In such cases, the best available evidence – that which is judged to be the most reliable and compelling – can be used, but with caution.

Bias

In statistics, bias is the difference between the estimator's expected value and the true value of the parameter being estimated. Although the term bias sounds pejorative, bias is tolerated and sometimes even welcomed in statistics.

Biological Agent Outbreak

Biological agents are infectious microbes or toxins used to produce illness or death in people, animals or plants. An outbreak exists when there are more cases of a particular illness or disease than expected in a given area or among a specific group of people over a particular period of time.

Birth Rate

The average annual number of births during a year per 1,000 population. Also known as the crude birth rate.

Board of Health

A legally designated governing body whose members are appointed or elected to provide advisory functions and/or governing oversight of public health activities, including assessment, assurance, and policy development, for the protection and promotion of health in their community.

Body Mass Index

This index mathematically relates height and weight for a result that is a good indicator of body fat. It is a better predictor of health risk than weight alone. This formula is most accurate for adults other than body builders, competitive athletes, and pregnant or breast feeding women. Body Mass Index (BMI) is determined by calculating the weight in kilograms divided by the height in meters squared. BMI = (weight in kilograms) / (height in meters)2.

BRFSS

Behavioral Risk Factor Surveillance Survey. A national survey of behavioral risk factors conducted by states with CDC support.

C

Capacity

The ability of an individual, organization or system to effectively complete specific tasks over time and across issues.

Capacity Building

The process of developing or acquiring the skills, competencies, and tools, processes and resources that are needed to improve the ability of an individual, organization or system to achieve its identified objectives.

Case-Control Study

A study in which people diagnosed as having a disease (cases) are compared with persons who do not have the disease (controls). Also referred to as a retrospective study.

Causality

The relationship between two variables whereby a change in one is followed by a change in the other. The criteria used to assess the likelihood of the causal nature of an association are:

- consistency
- temporal correctness
- specificity
- coherence (biological plausibility)
- strength

Cause of Death

Any condition that leads to or contributes to death and is classifiable according to the International Classification of Diseases.

Cause-Specific Death Rate

A rate which approximates the risk of death from a specific condition; differences in the magnitude of this measure in subgroups and by time and place suggest etiologic hypotheses and document the need for control measures.

CDC

The Centers for Disease Control and Prevention.

Coalition

A group of individuals and/or organizations that join together for a common purpose.

Cohort Study

A study which starts with a group of people (a cohort), all considered to be free of a given disease, but who vary in exposure to a supposed noxious factor. The cohort is followed over time to determine differences in the rate at which disease develops in relation to exposure to the factor. Also referred to as a prospective study.

Communicable Disease

An illness which is caused by a specific infectious agent or its toxic products and which arises through transmission of that agent or its products from a reservoir to a susceptible host – either "directly", as from an infected person or animal, or "indirectly", through the agency of an intermediate plant or animal host, vector, or the inanimate environment.

Community

The aggregate of persons with common characteristics such as geographic, professional, cultural, racial, religious, or socio-economic similarities; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other common bonds.

Community Assets

Contributions made by individuals, citizen associations, and local institutions that individually and/or collectively build the community's capacity to assure the health, well being, and quality of life for the community and all its members.

Community Collaboration

A relationship of working together cooperatively toward a common goal. Such relationships may include a range of levels of participation by organizations and members of the community. These levels are determined by: the degree of partnership between community residents and organizations, the frequency of regular communication, the equity of decision making, access to information, and the skills and resources of residents. Community collaboration is a dynamic, ongoing process of working together, whereby the community is engaged as a partner in public health action.

Community Health

A perspective on public health that assumes community to be an essential determinant of health and the indispensable ingredient for effective public health practice. It takes into account the tangible and intangible characteristics of the community, its formal and informal networks and support systems, its norms and cultural nuances, and its institutions, politics, and belief systems.

Community Health Assessment (CHA)

In New York State, the Department of Health (NYSDOH) requests that each county prepare a community health assessment on a regular basis. The community health assessment, or CHA, identifies those health issues of most concern in the county. Among those issues, a smaller number usually are selected as priority health issues. For those priority health issues, additional detail is provided, additional data collection occurs, stakeholders are identified and invited to participate, and action items are formulated. Progress is charted and reported on in the next CHA document.

Community Health Improvement Process

The community health improvement process involves an ongoing collaborative, community wide effort to identify, analyze, and address health problems; assess applicable data; develop measurable health objectives and indicators; inventory community health assets and resources; identify community perceptions; develop and implement coordinated strategies; identify accountable entities; and cultivate community ownership of the entire process.

Community Health Needs

Traditionally defined as the gaps and deficiencies identified through a community health assessment that need to be addressed. However, there is increasing recognition that gaps and deficiencies must be balanced with recognition of building on strengths identified in the community.

Community Health Profile

A comprehensive compilation of measures representing multiple categories that contribute to a description of health status at a community level and the resources available to address health needs. Measures within each category may be tracked over time to determine trends, evaluate health interventions or policy decisions, compare community data with peer, state, national, or benchmark measures, and establish priorities through an informed community process.

Community Health Status

Health status in a community is measured in terms of mortality (rates of death within a population) and morbidity (the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates; by degree of premature death (Years of Productive Life Lost); and by cause (disease--cancer and non-cancer or injury--intentional, unintentional). Morbidity may be represented by age-adjusted incidence of disease.

Community Partnerships

A continuum of relationships that foster the sharing of resources, responsibility and accountability in undertaking activities within a community. A cooperative relationship formed between two or more organizations to achieve a shared goal or pursue a common interest.

Community Support

Actions undertaken by those who live in the community that demonstrate the need for and value of, a healthy community and an effective local public health system. Community support often consists of, but is not limited to, participation in the design and provision of services, active advocacy for expanded services, participation at board meetings, support for services that are threatened to be curtailed or eliminated, and other activities that demonstrate that the community values a healthy community and an effective local public health system.

Confidence Interval

A range of values that is normally used to describe the uncertainty around a point estimate of a quantity, for example, a mortality rate. Therefore confidence intervals are a measure of the variability in the data.

Constituency

Organizations and individuals that have an interest in the activities performed by the public health organization. Constituencies are often defined to include clients of public health programs, staff, community residents, policymakers, governing board members, health related organizations and professionals in the community, and area businesses and employers.

Constituency Development

The ongoing identification and involvement of individuals and organizations in the process of applying community resources to identified community health priorities. Constituency building is the process of establishing collaborative relationships among the Local Public Health system and all current and potential constituents.

Contributing Factors

Those factors that directly or indirectly influence a risk factor's influence on a specific health problem (also referred to as causative factors, risk factors, or determinants).

Core Indicators

The core indicators have a higher priority based on the critical nature of the data, potential for comparative value, and relevance to most communities. An element used to measure health status, risk or outcome. A measure of health status or a health outcome.

Crude Rate

A summary rate based on the actual number of events (e.g., births or deaths) in a total population over a given time period. A rate that has not been "adjusted" or "standardized" for any other factor, such as age.

D

Death, Illness, and Injury

Health status in a community is measured in terms of mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates; by degree of premature death (Years of Productive Life Lost); and by cause (disease - cancer and non-cancer or injury - intentional, unintentional). Morbidity may be represented by age-adjusted incidence of cancer and chronic disease. This is a category of data recommended for collection within the Community Health Status Assessment.

Demographic Characteristics

Demographic characteristics include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub-populations are located, and the rate of change in population density over time, due to births, deaths and migration patterns. This is a category of data recommended for collection within the Community Health Status Assessment. Characteristic data such as size, growth, density, distribution, and vital statistics are used to study human population. Demographic characteristics of your jurisdiction include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub populations are located, and the rate of change in population density over time, due to births, deaths and migration patterns.

Determinants (or Risk Factors)

Direct causes and risk factors which, based on scientific evidence or theory, are thought to influence directly the level of a specific health problem. Broad causal factors involved in influencing health and illness, include social, economic, genetic, perinatal, nutritional, behavioral, and environmental characteristics. A primary risk factor (causative factor) is associated with the level of health problem.

Disadvantaged Groups

Disadvantaged (or vulnerable or marginalized) applies to groups of people who, due to factors usually considered outside their control, do not have the same opportunities as other, more fortunate groups in society. Examples might include unemployed people, refugees and others who are socially excluded.

Distance Learning

A system and a process that connects learners with distributed learning resources characterized by: (1) separation of place or time between instructor and learner, among learners, or between learners and learning resources and (2) interaction between the learner and the instructor, among learners, or between learners and learning resources conducted through one or more media.

E

Economic Impact Assessment

Economic impact assessment involves exploring and identifying the ways in which the economy in general, or local economic circumstances in particular, will be affected by a policy, program or project.

Endemic

The habitual presence of a disease or infectious agent within a geographic area or the prevalence of a given disease within such an area.

Environmental Equity

The distribution and effects of environmental problems and the policies and processes to reduce differences in those who bear environmental risks. In contrast to environmental racism, equity includes consideration of the disproportionate risk burden placed on any population group, as defined by gender, age, income, and race.

Environmental Health

The quality of our physical environment, including air, water, and food, directly impacts health and quality of life. Exposure to environmental substances, such as lead or hazardous waste, increases risk for preventable disease. The application of multiple scientific disciplines to investigate the relationship between environmental factors and human health, and to prevent adverse health events that result from environmental exposures. The interrelationships between people and their environment that promote human health and well being and foster a safe and healthful environment.

Environmental Health Indicators

The physical environment directly impacts health and quality of life. Clean air and water, as well as safely prepared food, are essential to physical health. Exposure to environmental substances, such as lead or hazardous waste, increases risk for preventable disease. Unintentional home, workplace, or recreational injuries affect all age groups and may result in premature disability or mortality. This is a category of data recommended for collection within the Community Health Status Assessment.

Environmental Justice

The fair treatment and meaningful involvement of all people, regardless of race, ethnicity, culture, income or education level with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. Environmental justice seeks to ensure that no population is forced to shoulder a disproportionate burden of the negative human health and environmental impacts of pollution or other environmental hazards.

Environmental Risk

The likelihood of eating, drinking, breathing, or contacting some unhealthy factor in the environment and the severity of the illness that may result; the probability of loss or injury; a hazard or peril.

Epidemic

The occurrence in a community or region of a group of illnesses of similar nature in excess of normal expectancy. A common-source epidemic in which one human or one animal or a specific vehicle (limited as to location and amount) has served as the primary means of transmitting infection to the cases identified. A propagated-source epidemic: An epidemic in which infections are transmitted from person-to-person or animal-to-animal in such a fashion that cases identified cannot be attributed to transmission from a single individual or animal.

Epidemiology

The study of the distribution and determinants of health related states or events in specified populations, and the application of this study to control health problems. The study of the distribution of determinants and antecedents of health and disease in human populations; the ultimate goal is to identify the underlying causes of a disease and then apply findings to disease prevention and health promotion. The study of disease mechanisms and health processes in populations, including disease etiology, disease transmission, disease prevention, and disease control. The discipline of epidemiology focuses on the interaction of host factors, disease agents, and environmental conditions in determining disease transmission and progression.

Equity in health

Inequity has a moral and ethical dimension, resulting from avoidable and unjust differentials in health status. Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential if it can be avoided. More succinctly, equity is concerned with creating equal opportunities for health and with bringing health differentials down to the lowest possible level.

Essential Public Health Services

Ten essential services, include:

- monitoring health status to identify community health problems
- diagnosing and investigating health problems and health hazards in the community
- informing, educating, and empowering people about health issues
- mobilizing community partnerships to identify and solve health problems
- developing policies and plans that support individual and community health efforts
- enforcing laws and regulations that protect health and ensure safety

- linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable
- ensuring a competent public health and personal health care work force
- evaluating effectiveness accessibility, and quality of personal and population-based health services,-research for new insights and innovative solutions to health problems.

Evidence Based

Evidence based refers to a body of information, drawn from routine statistical analyses, published studies and "grey" literature, which tells us something about what is already known about factors affecting health. For example, in the field of housing and health there are a number of studies which demonstrate the links between damp and cold housing and respiratory disease and, increasingly, the links between high quality housing and quality of life.

F

Family

A group of two or more people who reside together and who are related by birth, marriage, or adoption.

Family Household

A family household consists of a householder and one or more people living together in the same household who are related to the householder by birth, marriage, or adoption. All people in a household who are related to the householder are regarded as members of his or her family. People not related to the householder are not included as part of the householder's family in census tabulations. In 1950 and 1960, a household enumerated in the census could contain more than one family. Thus, there were more families than family households. From 1970 to 2000, each family household in the census could contain only one family, resulting in an equal number of families and family households.

Fertility Rate

Annual number of live births per 1,000 female population, aged 15-44.

Fetal death ratio

The number of fetal deaths after 20 weeks gestation in a defined population and time period divided by the number of live births in that population and time period.

G

Geocode

Addresses matched and assigned to a corresponding latitude and longitude. The process of assigning geographic location information to attribute data that are to be used for analytic purposes.

Geographic Information System (GIS)

GIS combines modern computer and supercomputing digital technology with data management systems to provide tools for the capture, storage, manipulation, analysis, and visualization of spatial data. Spatial data contains information, usually in the form of a geographic coordinate system, that gives data location relative to the earth's surface. These spatial attributes enable previously disparate data sets to be integrated into a digital mapping environment. Geographic information systems that are computer based processes for capturing, lining, summarizing, and analyzing data containing geographical location information. These systems are particularly useful in supporting visual analysis and communication of data using maps that display the geographic distribution of data.

H

Health

A dynamic state of complete physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending on the cultural milieu and on the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms of morbidity and mortality.

Health Belief Model

A theory stating that the likelihood of taking a preventive health action will be determined by one's perceived susceptibility (the individual's perception about his or her own likelihood of contracting a condition); by the perceived severity (the seriousness the individual would assign to such a condition were it to happen); by the perceived benefits of the proposed action (the individuals perception about the likelihood that a given action would succeed in reducing or eliminating harm); and by the perceived barriers (factors that would interfere with the individual taking the desired action).

Health Care

The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.

Health Disparity

A statistically significant difference in a health indicator between groups that persist over time.

Health Equity

Distribution of disease, disability and death in such a way as to not create a disproportionate burden on one population; the absence of persistent health differences over time, between racial and ethnic groups.

Health Gain

Improvement in health status.

Health Impact

A health impact can be positive or negative. A positive health impact is an effect which contributes to good health or to improving health. For example, having a sense of control over one's life and having choices is known to have a beneficial effect on mental health and well being, making people feel "healthier". A negative health impact has the opposite effect, causing or contributing to ill health. For example, working in unhygienic or unsafe conditions or spending a lot of time in an area with poor air quality is likely to have an adverse effect on physical health status.

Health Indicator

A health indicator is a numeric value for a specific health-related occurrence, such as the percentage of smokers or the number of people diagnosed with cancer within a given population. Health indicators are documented over-time to assess trends and compare values in the local population to state and national averages. While health indicators are important for understanding the depth and breadth of a health problem, data alone cannot solve health problems. Solutions require health experts and community stakeholders working together to understand the context and influences on the problem, including the demographic, social, environmental, and economic characteristics within the population.

Health Inequality and Inequity

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health.

Health Issues

Health issues summarize or categorize the health indicators of most concern within a population. A health issue can be a particular disease such as chronic or infectious disease. A health issue also can be the social, economic, or behavioral conditions that are causing or exacerbating a disease. For example, tobacco use, poor diet and lack of physical fitness are health issues because they are known to directly contribute to diseases of the heart, lungs, and circulatory system. Health issues usually are comprised of multiple health indicators and efforts to address and improve a health issue require broad-based community attention and support.

Health Insurance Coverage

A person is considered covered by health insurance at some time during the year if he or she was covered by at least one type of coverage.

Health Promotion

Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities. An intervention strategy that seeks to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. This process enables individuals and communities to control and improve their own health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and work in partnerships that build on existing skills and strengths. Any combination of educational, organizational, environmental, and economic interventions designed to encourage behavior and conditions of living that are conducive to health.

Healthy People 2010

A national health promotion and disease prevention initiative that brings together national, state, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life. In Healthy People 2010, 467 health promotion and disease prevention objectives are identified for achievement by the year 2010. There will be a Healthy People 2020 initiative.

Household

One person or a group of people living in a housing unit.

Housing Unit

A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied or intended for occupancy, as separate living quarters. Separate living quarters are those in which the occupant(s) live separately from any other people in the building and which have direct access from outside the building or though a common hall.

I

Impact Assessment

Impact assessment is about judging the effect that a policy or activity will have on people or places. It has been defined as the prediction or estimation of the consequences of a current or proposed action.

Impact Objective

A short term (less than three years) and measurable. The object of interest is on knowledge, attitudes, or behavior.

Incidence

A measure of the health condition in the population; generally the number of new cases occurring during a specified time period.

Indicator

A measurement that reflects the status of a system. Indicators reveal the direction of a system (a community, the economy, and the environment), whether it is going forward or backward, increasing or decreasing, improving or deteriorating, or staying the same. A measure of health status or a health outcome. An element used to measure health status, risk, or outcome. See also "Health Indicator"

Inequalities Audit or Equity Audit

A review of inequalities within an area or of the coverage of inequalities' issues in a policy, program or project, usually with recommendations as to how they can be addressed.

Infrastructure

The resources (e.g., personnel, information, monetary, and organizational) used by the public health system to provide the capacity to perform its duties.

Infant Mortality Rate

The number of deaths to infants less than 1 year of age occurring during the year per 1,000 births.

Integrated Impact Assessment

Integrated impact assessment brings together components of environment, health, social and other forms of impact assessment in an attempt to incorporate an exploration of all the different ways in which policies, programs, or projects may affect the physical, social and economic environment.

Intervention

A public health program intended to improve the health of a specific population or the overall population. The focus of a public health intervention is to prevent rather than treat a disease through surveillance of cases and the promotion of healthy behaviors. Interventions can be used to create change in different settings, including: communities, worksites, schools, health care organizations, faith-based organizations or at home. Interventions may be most effective when they include multiple settings.

Infant Mortality Rate

A death rate calculated by dividing the number of infant deaths during a calendar year by the number of live births reported in the same year. It is expressed as the number of infant deaths per 1,000 live births. The annual number of live-born infants who die during their first year of life, expressed per 1,000 live births, often broken into two components, neonatal mortality (deaths before 28 days per 1,000 live births) and post neonatal mortality (deaths from 28 days through the rest of the first year of life per 1,000 live births.

Injury

Injuries can be classified by the intent or purposefulness of occurrence in two categories, intentional and unintentional injuries. Intentional injuries are ones that are purposely inflicted and often associated with violence. These include child abuse, domestic violence, sexual assault, aggravated assault, homicide, and suicide. Unintentional injuries include only those injuries that occur without intent of harm and are not purposely inflicted.

International Classification of Disease (ICD-10-CM)

The ICD-10 is used to code mortality data. Its purpose is to provide a common language, specifically number and letter codes, for identifying illnesses, injuries and causes of death. This enables communities, health care organizations, insurance companies, regulatory agencies, etc. to compare rates of disease and injury, as well as allowing comparison of cost and pricing practices.

L

Latent Period

The interval of time from exposure to chemical agents and the onset of signs and symptoms of the illness.

Leading Causes of Death

The leading causes of death in the United States are heart disease, cancer, stroke, and respiratory disease, in that order. There are lifestyle and behavioral factors such as smoking and physical inactivity that contribute to this nation's leading killers. In 2000, the most common actual causes of death in the United States were tobacco (435,000), poor diet and physical inactivity (400,000), alcohol consumption (85,000), microbial agents (e.g., influenza and pneumonia, 75,000), toxic agents (e.g., pollutants, asbestos, etc., 55,000), motor vehicle accidents (43,000), firearms (29,000), sexual behavior (20,000) and illicit use of drugs (17,000).

Life Expectancy at Birth

The average number of years a hypothetical group of people born in a specified year would live if they experienced over their lifetime the mortality rates at each year of age that occurred in the specified year (e.g., 1900 or 2000).

Local Health Department

An administrative or service unit of local or state government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than the state. Functionally, a local (county, multicounty, municipal, town, other) health agency, operated by local government, often with oversight and direction from a local board of health, that carries out public health's core functions throughout a defined geographic area. A more traditional definition is an agency serving less than an entire state that carries some responsibility for health and has at least one full time employee and a specific budget.

M

MAPP - Mobilizing for Action through Planning and Partnerships

A community-wide strategic planning tool.

Market Justice

Health care, like other social, economic and political resources or opportunities in the United States, competes for consumers in the marketplace. Market justice distributes health care based on individual resources and choices, not a collective or community responsibility. Market justice is based on principles of individualism, voluntary behavior and self-interest.

Maternal and Child Health

A category focusing on birth data and outcomes as well as mortality data for infants and children. Because maternal care is correlated with birth outcomes, measures of maternal access to, and/or utilization of, care is included. One of the most significant areas for monitoring and comparison relates to the health of a vulnerable population: infants and children. Births to teen mothers is a critical indicator of increased risk for both mother and child. This is a category of data recommended for collection within the Community Health Status Assessment.

Mean

The measure of central location commonly called the average. It is calculated by adding together all the individual values in a group of measurements and dividing by the number of values in the group.

Median

The measure of central location which divides a set of data into two equal parts.

Median Age

The median divides the age distribution into two equal parts, one-half of the population falling below the median age and one-half above the median.

Mental Health

A term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined.

Morbidity

The condition of being sick or diseased, the prevalence of a disease in a population.

Mortality Rate

The number of deaths from a given condition in a defined population in a specified time period, the ratio of deaths in an area to the population of that area, can be crude or age-adjusted.

N

Natality

Natality is another term for births.

Neonatal Death Rate

The number of deaths among infants under 28 days of age in a defined population and time period divided by the number of live births in that population and time period.

O

Outbreak

The occurrence of two or more cases which are epidemiologically related.

Outcome Objective

The level to which a health problem is to be reduced as a result of an intervention, usually measured in terms of mortality, morbidity, or disability. An outcome objective usually is long term (greater than 3 years) and measurable.

P

Pandemic

A widespread epidemic disease affecting several countries or continents.

Perinatal Mortality Rate

The number of deaths among infants under seven days of age and fetuses over 28 weeks gestation in a defined population and time period divided by the number of live births plus fetal deaths in that population and time period.

Per Capita Income

The per capita income for an area is defined as the total personal income in an area, divided by the number of people in that area. The Census Bureau derived per capita income by dividing the total income of a particular group by the total population in that group (excluding patients or inmates in institutional quarters).

Policy Development

One of public health's three core functions, the others are assessment and assurance. Processes by which public health organizations formulate policies and plans to address priority health issues for the populations they serve, and advocate for the adoption and implementation of these policies by legislative and regulatory bodies and by private sector institutions. The means by which problem identification, technical knowledge of possible solutions, and societal values converge to set a course of action. Policy development processes typically involve planning and priority-setting efforts that include broad participation by community members as well as health-related professionals and institutions. Policy development is not synonymous with the development of laws, rules, and regulations. Laws, rules, and regulations may be adopted as tools among others to implement policy. Policy development is a process that enables informed decisions to be made concerning issues related to the public's health. Policy development involves serving the public interest in the development of comprehensive public health policies by promoting the use of the scientific knowledge base in decision making and by leading in developing public health policy.

Population Health

An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.

Population Projections

A calculation of population size derived for future dates using assumptions about future trends and data from population censuses, administrative records, sample surveys, and/or other sources.

Pregnancy Rate

Annual number of pregnancies per 1,000 female population aged 15-44.

Prevalence

The number of cases of a disease, infected people or people with some other attribute present during a particular interval of time. It often is expressed as a rate.

Prevention

An active process that promotes the personal, physical and social well-being of individuals and families to reinforce positive health behaviors and lifestyles that minimize morbidity and maximize the overall quality of life. Primary care can be viewed as a form of prevention as its proper use can result in fewer hospitalizations for conditions such as asthma, diabetes, chronic obstructive pulmonary disease, and congestive heart failure, which are affected by the level of care given on an outpatient basis.

Preventive Care

A set of measures taken in advance of symptoms to prevent illness or injury. This type of care is best exemplified by routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur.

Process Objective

A process objective is short term and measurable. The object of interest is the level of professional practice in the completion of the methods established in a Community Health Plan. Process objectives may be evaluated by audit, peer review, accreditation, certification, or administrative surveillance. Objects of evaluation may include adherence to projected timetables, production, distribution, and utilization of products, and financial audits.

Proportional Mortality

The relative importance of a specific cause of death in relation to all deaths in a population group. The two measures in the proportional mortality rate are measured over the same period of time.

Public Health

The mission of public health is to fulfill society's desire to create conditions so that people can be healthy. Activities that society undertakes to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, and counter threats to the health of the public.

Public Health Leadership

This is demonstrated by both individuals and organizations that are committed to the health of the community. Leadership defines key values and guides action; participates in scanning the environment both internal and external for information critical to implementing the public health mission; keeps the public health mission in focus and articulates it clearly; and facilitates the creation of a vision of excellence, a compelling scenario of a preferred future. Through shared information and decision making, public health leadership facilitates the empowerment of others to create and implement plans to enact the shared vision and to participate actively in the process of community health improvement.

Public Health Mission

To fulfill society's interest in assuring conditions in which people can make choices to be healthy in their communities. Public health carries out its mission through organized, interdisciplinary efforts that help prevent and treat the physical, mental and environmental health concerns of communities and populations.

Public Health System

The network of organizations and professionals that participate in producing public health services for a defined population or community. This network includes governmental public health agencies as well as relevant health care and social service providers, community based organizations, and private institutions with an interest in population health.

Public Hygiene

Includes public behaviors that individuals can take to improve their personal health and wellness. Topics include public transportation, food preparation and public washroom use. These are steps individuals can take themselves. Examples would include avoiding crowded subways during the flu season, using gloves when touching handrails and opening doors in public malls, as well as eating at clean restaurants.

Q

Quality of Life

A construct that connotes an overall sense of well-being when applied to an individual and a supportive environment when applied to a community. While some dimensions of quality of life can be quantified using indicators that research has shown to be related to determinants of health and community well being, other valid dimensions include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life.

R

Race/Ethnicity

Race and ethnicity are social, not biological constructs, referring to social groups often sharing cultural heritage and ancestry. Race and ethnicity are not valid biological or genetic categories. As per the U.S. Census, prior to 1980, race was determined either solely by the observation of the enumerator or by a combination of enumerator observation and self-identification. These categories reflect social usage and should not be interpreted as being scientific or anthropological in nature. Furthermore, the race categories include both racial and national-origin groups.

Racial and Ethnic Health Disparities

Persistent differences in health indicators by race and ethnicity across multiple categories (chronic disease, communicable disease, intentional and unintentional injuries and maternal and child health indicators).

Random

Chance used to refer to the type of error that results from fluctuations around a value because of sampling variability.

Rate

A measure of some event, disease or condition in relation to a unit of population where time and place are stated. A true rate can be determined only if the numerator is included as part of the denominator if the denominator represents the entire population at risk and a unit of time is specified.

Ratio

A relative number expressing the magnitude of one occurrence or condition in relation to another.

Relative Risk

The ratio of the incidence rate of those exposed to a factor to the incidence rate of those not exposed.

Resource Allocation

The process of deciding what is needed to carry out an activity and providing for those needs. This can include making provision for financial resources (money), capital resources (such as buildings and computer hardware) and staff resources (including the number of staff needed and the skill mix required).

Risk Assessment

The scientific process of evaluating adverse effects caused by a substance, activity, lifestyle, or natural phenomenon. Risk assessment is the means by which currently available information about public health problems arising in the environment is organized and understood. A systematic approach to quantifying the risks posed to individuals and populations by environmental pollutants and other potentially harmful exposures.

Root Causes

Root causes are primary causes of health problems that underlie the more obvious causes. Social problems are often root causes that result in health inequalities through complex pathways. For example, racism is a root cause because it results in income inequality, lack of power, residential and occupational segregation, and stress in marginalized groups. These things in turn cause things like inadequate health care, working in dangerous environments, living in cramped conditions where infections spread easily, smoking, and the inability to afford nutritious food. These things, in turn, are related to a host of health problems like injury, infectious and chronic disease, and mental illness. While addressing root causes will not eliminate disease and death, it will reduce health disparities between populations.

S

Sentinel Health Event

Sentinel events are those cases of unnecessary disease, disability, or untimely death that could be avoided if appropriate and timely medical care or preventive services were provided. These include vaccine-preventable illness, late stage cancer diagnosis, and unexpected syndromes or infections. Sentinel events may alert the community to health system problems such as inadequate vaccine coverage, lack of primary care and/or screening, a bioterrorist event, or the introduction of globally transmitted infections.

Social Impact Assessment

Social impact assessment is the process of assessing or estimating, in advance, the social consequences that are likely to follow from specific policy actions or project development, particularly in the context of appropriate national, state or provisional policy legislation. It is based on the assumption that the way in which the environment is structured can have a profound effect on people's ability to interact socially with other people and to develop networks of support. For example, a major road cutting across a residential area can have the effect of dividing a community with implications for social cohesion.

Social Justice/Equity

Social justice is the equitable distribution of social, economic and political resources, opportunities, and responsibilities and their consequences. The Social Justice Framework claims there is marginalization based on race, class, gender, and other social classifications that underlie the inequitable distribution of social justice. This unequal distribution of resources and opportunities is manifested through inequitable access and exposure to social determinants of health.

Socioeconomic Characteristics

Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables.

Specificity

The ability to identify correctly those who do not have a given disease.

Standard Population

The age distribution of a population for a given period of time.

Strategic Planning

A disciplined effort to produce fundamental decisions and actions that shape and guide what an organization (or other entity) is, what it does, and why it does it. Strategic planning requires broad scale information gathering, an exploration of alternatives, and an emphasis on the future implications of present decisions. It can facilitate communication and participation, accommodate divergent interests and values, and foster orderly decision making and successful implementation.

Strategies

Patterns of action, decisions, and policies that guide a group toward a vision or goals. Strategies are broad statements that set a direction. They are pursued through specific actions (i.e., those carried out in programs and services of individual components of the local public health system).

Statistical Significance

In statistics "significant" means a finding is probably true and reliable and not due to chance. Significance levels show how likely a result is due to chance. The most common level, used to mean something is good enough to be believed, is 95%. This means that the finding has a 95% chance of being true. When quantitative differences found between populations are labeled as statistically significant, it means the differences are considered highly likely to be real and are not due to mere coincidence (random error). For example, if the diabetes rate for Hispanics is higher than the rate for other racial/ethnic groups and those differences are statistically significant, it means the rates probably reflect true disparities between groups.

Surveillance

The systematic collection, analysis, interpretation, and dissemination of health data to assist in the planning, implementation, and evaluation of public health interventions and programs. Systematic monitoring of the health status of a population. The process of collecting health related data that are representative of a population of interest, for use in assessing trends in disease and other health conditions, measuring the prevalence of health risk factors and health behaviors, and monitoring the use of health services.

Sustainability

The long-term health and vitality - cultural, economic, environmental, and social - of a community. Sustainable thinking considers the connections between various elements of a healthy society, and implies a longer time span (i.e., in decades, instead of years).

Systems Change

The process of improving the capacity of the public health system to work with many sectors to improve the health status of all people in a community.

T

Teenage Birth Rate

Annual number of live births to women aged 15-19 per 1,000 female population aged 15-19.

Teen Pregnancy Rate

Annual number of pregnancies to women aged 15-19 per 1,000 female population aged 15-19.

U

Underlying Cause of Death

The disease or injury that initiated the sequence of events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury.

V

Values

The fundamental principles and beliefs that guide a community driven process. These are the central concepts that define how community members aspire to interact. The values provide a basis for action and communicate expectations for community participation.

Vision

A compelling and inspiring image of a desired and possible future that a community seeks to achieve. A health vision states the ideal, establishes a stretch linked explicitly to strategies, inspires commitment, and draws out community values. A vision expresses goals that are worth striving for and appeals to ideals and values that are shared throughout the local public health system.

Vital Events

Live births, deaths, fetal deaths, marriages, divorces, and induced terminations of pregnancy, together with any change in civil status that may occur during an individual's lifetime.

Vital Statistics

Data derived from certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage, (divorce, dissolution of marriage, or annulment) and related reports. Information compiled by state health agencies concerning births, deaths, marriages, divorces, fetal deaths, and abortions.

W

WIC

Special Supplemental Program for Women, Infants and Children.

Workforce Assessment

The process of determining the personnel, training, skills, and competencies needed to achieve communitywide public and personal health goals. This community process includes the identification of those available to contribute to providing the essential public health services and their particular strengths and assets. The assessment included the use of performance measures for identified competencies, the identification of needed professional personnel, and the formulation of plans to address identified workforce shortfalls or gaps.

Workforce Standards

The professional and technical requirements or position qualifications (certifications, licenses, and education) required by law or established by local, state, or federal policy guidelines. These standards are linked to actual job performance through clearly written job descriptions and regular performance evaluations.

Y

Years of Life Lost

A measure of premature mortality. The measure subtracts the person's age at death from the life expectancy for someone that age in a standard population. The younger the age at death, the greater the Years of Life Lost. Since many younger deaths could be prevented or postponed, this measure has implications for prevention efforts.

Years of Potential Life Lost

This measure of premature mortality is the number of years between the age at death and age 65 or 75, that is, the number of years which are "lost" by persons who die before one of those ages. This approach places additional value on deaths that occur at earlier ages.

Appendices

The following represents the findings of the individual County Community Health Assessments and the Community Service Plans for the six hospitals in the Adirondack Region.

Community Health Assessment

Essex County Public Health

Fulton County Public Health

Hamilton County Public Health Nursing Service

Saratoga County Public Health Nursing Service

Warren County Health Services

Washington County Public Health

Community Service Plan

Adirondack Medical Center

Elizabethtown Community Hospital

Glens Falls Hospital

Moses-Ludington Hospital

Nathan Littauer Hospital and Nursing Home

Saratoga Hospital

Adirondack
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